SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

38th Meeting

Wednesday,
December 7, 2005

Sugarloaf Mountain and Seneca Rooms
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, Maryland

IN ATTENDANCE:

Acting Chairperson and Executive Director

Daryl W. Kade, M.A.
Executive Director, SAMHSA National Advisory Council
Associate Administrator for Policy, Planning,
and Budget, SAMHSA
1 Choke Cherry Road, Room 8-1083
Rockville, MD 20857

Executive Secretary

Toian Vaughn, M.S.W.
Executive Secretary, SAMHSA National Advisory Council
1 Choke Cherry Road, Room 8-1089
Rockville, MD 20857

Members

Gwynneth A. E. Dieter
Mental Health Advocate
U.S. Embassy Belize
Unit 7401

Faye Annette Gary, Ed.D., R.N.
Professor, Case Western Reserve University
Frances Payne Bolton School of Nursing
1099 Euclid Avenue
Cleveland, OH 44106-4904

Barbara Huff
Consultant
The Federation of Families for Children's Mental Health
2837 North Plumthicket Circle
Wichita, KS 67226

Thomas A. Kirk, Jr., Ph.D.
Commissioner
Department of Mental Health and Addiction Services
410 Capitol Avenue, 4th Floor
P.O. Box 341231, MS #14 Com
Hartford, CT 06134

IN ATTENDANCE:

Thomas Lewis
President and CEO
The Fishing School
7017 16th Street, N.W.
Washington, D.C. 20012

Theresa Racicot
Former First Lady of Montana
901 15th Street South #201
Arlington, VA 22202

Kenneth D. Stark
Director
Division of Alcohol and Substance Abuse
Department of Social and Health Services
P.O. Box 45330
Olympia, WA 98504-5330

Kathleen Sullivan
Journalist
Four Mission Court
Rancho Mirage, CA 92270

C O N T E N T S

C O N T E N T S

P R O C E E D I N G S (9:00 a.m.)

MS. KADE: Good morning, everyone. We're about to begin. Anita Everett is going to talk with us about the Medicare Modernization Act.

MS. EVERETT: Thank you. Medicare recipients, because of their age, because they're past 65, about 14 percent of them are disabled. They are on Medicare because they're disabled. So by far and away, the majority of the population, the beneficiaries that are eligible for this benefit, are geriatric individuals.

Of those 42 million, about 7 million are what we call dually eligible individuals, or they are people that have both Medicaid and Medicare. That's a particular concern to us at SAMHSA, because maybe those individuals are dually eligible in association with a mental illness and/or substance abuse, but primarily mental illness. So that's a high impact population.

The other thing that's particularly important about that group of people, or the duals as they're called, is that because of the way the law is set up, the interaction of federal laws, those individuals no longer can receive their medications through Medicaid, so they switch over to Medicare as of January 1st, 2006.

So whereas individuals who have been used to getting their medicines through Medicaid with all the

systems and the access that goes on with that, this will also cover the Medicare benefit. So that is a group that we have been following and working with CMS quite closely on.

The other group that's particularly likely to benefit from this is the low income individuals. There are actually three tiers of beneficiaries by financial assets. There is the Medicare individuals which will meet their state requirements for Medicaid eligibility, and then there is the in between group that are called low income groups. We right now are actively trying to get people to make sure they sign up for this benefit.

Those are individuals that are 150 percent of the federal poverty level and less, and those individuals, there are no premiums, very limited co-pays, and their deductible is very limited. It depends a little bit on their assets. So that's a population that's going to benefit tremendously from this benefit.

Other than that, the other sorts of things in particular in the whole benefit that SAMHSA has been working very closely with CMS on is the special provisions that are made for people with mental illness with regards to this. Because of concern that certain populations would be highly impacted by the benefit itself, and remember the whole benefit is sort of couched on the idea of encouraging

competition between the companies and making arrangements with individual prescription drug plans. So competition is the cornerstone of this whole thing.

There are certain special categories that were created by CMS with our encouragement that provide extra access to certain sets of medications. There are six categories of special interest, three of which concern medications which individuals with mental illness often need. Those would be antidepressants, antipsychotics, and anticonvulsants, which are often used for the treatment of bipolar disorder and mood disorders.

The other three are immunosuppressants. In other words, a common use for that would be transplant individuals, chemotherapy agents, and HIV/AIDS drugs. So those are the six categories.

What is special about those categories of medicines is that rather than the norm, which is that two medicines in each category have to be covered by each of these drug plans, all of the medicines in those categories have to be covered by each of the plans everywhere.

As the plans which have come out which they have in mid October, we found that there is pretty good adherence to that. In other words, CMS has provided oversight to them, and they follow through with that. So there are about six, for instance, of what we call atypical

antipsychotic agents. All of those are available on all of the prescription drug plans for individuals to access.

So that's the broad benefit. Certainly I can answer any questions if anybody has any. We've been working very closely with CMS on that. What I thought I would do is just run down some of the things that SAMHSA particularly has been doing. That is what is highlighted for you on this single page handout. Has that been distributed? You have that.

These are some of the activities that SAMHSA has done. This is a high priority of course for the administration, and also for Mr. Curie. So these are some of the activities, just sort of a listing of things that we have been engaged with SAMHSA on behalf of things that CMS is primarily responsible for administering.

We focus mostly on education and outreach in the areas of mental health and substance abuse, so that portions of this entire benefit are more likely to impact individuals with mental health and substance abuse issues.

Administrator Curie, as well as other agency leads, have been incorporating specific information about the prescription drug benefit, sort of their regular numerous national public appearances that they make throughout their time here, primarily encouraging people to sign up for the benefit and representing the basic

information on what the benefit represents.

We have created an email list to the states through their state mental health directors and substance abuse directors to send that to the person within that state who is the lead on this particular benefit. Sometimes it is in the Mental Health office, sometimes it is in other offices within state government, the way states are organized. So we have an email list of all the state leads on this project.

When you send them information, we try to sort of cull information and send in information that's directly relevant to the populations that have mental illness and substance abuse.

We created a page on our SAMHSA website which is sort of a nexus of links to other pages. We have created an education of outreach partnerships with several mental health advocacy groups throughout interagency funding between us and CMS. The groups that were the recipients of this education and outreach oriented grant include the National Council of Community Behavioral Health, or NCCBH, NASMHPD, the National Association of State Mental Health Program Directors, the National Mental Health Association, and the National Alliance for the Mentally Ill.

We have participated in regular meetings. The

substance abuse advocacy community as a whole is not as centrally oriented towards this benefit, primarily because the medications are used in a different way from the treatment of substance abuse disorders. They are much more sort of ancillary to the treatment, rather than the center of the treatment.

However, we have engaged in several substance abuse groups so that they are aware of this and provide information to their membership on what this benefit is all about, and what opportunities it could represent for individuals that they are working with.

We have created opportunities for CMS staff to come and present mental health and substance abuse and provider group meetings for large groups, national meetings that CMS otherwise would probably have had less ability to access. We have dedicated an entire edition of the SAMHSA News to that, and that also should be a handout here. That is dedicated to the Medicare benefit.

We have promoted the prescription drug benefit through distribution of CMS brochures at SAMHSA booth exhibits. The other handout you have with this packet here is information that came directly from CMS. Actually, when I was given the opportunity to do this, a CMS staff person from downtown hand delivered this to me to provide to you, so hopefully you'll have a chance to look through that a

little bit.

This is a benefit that's sent out, it's a resource kit that is sent out for what CMS is calling Partners, for people who are in positions to help other recipients or beneficiaries sign up for the benefit directly.

We are providing training for SAMHSA staff. We have 520 employees, and we think it's important for our employees to know how to access this benefit on behalf of their parents, other family members, or other neighbors that may be enrolled to influence positively. That is actually happening next week to myself and the CMS staff coming here for the presentation regarding that.

Other more minor things like participating in education experiences, there is a grand rounds online series that we participated in to provide technical information to professionals on that.

That's pretty much the summary of what SAMHSA has been doing. I intended to give you a little bit of a snapshot of the broad benefit. I'm happy to answer questions if anyone has any particular questions about either SAMHSA's role in this or the benefit itself.

MS. SULLIVAN: We could be here all day.

MS. EVERETT: Right.

MR. KIRK: The dual eligibles are of particular

concern to us in Connecticut. Can you tell what the spirit is among CMS as to -- my understanding is that the plans, for example, the one was with 17 vendors and then there were 44 different variations of the plans, and that formulary can change on a fairly regular basis.

We'll get our people set to the medications that they're on. On average, they're on five. Two months later, the formulary can change, and we're going through the same thing again. We're concerned about people being moved to medications, generics, after they've been on medications for a long period of time, and decompensating as a result and going back into the hospital. We're simply trying to keep track of these kinds of changes.

What's the spirit of this? Does CMS understand this?

MS. EVERETT: My primary contact over at CMS is a Dr. Jeffrey Kellman, who is the chief medical officer of all of CMS and is in Mark McClellan's office. So that's the level that we've been interacting with.

I can tell you honestly through numerous interactions with them, they have been very receptive to our issues that relate to mental illness and special needs. That is part of the reason that we were successful in helping them identify those three methods in particular, groups of medicines, all of which should be available for

our individuals.

So the antipsychotics, the antidepressants, and the anticonvulsant medications should be available on all of the formularies. So you're right, that is a concern, but there are several things that are set up to safeguard people having to change with regards to that.

I'm not sure if I answered your question. People who have mental illness for those medicines should not have to change to a generic. There is no particular provision set up if the person is also on cardiac medicine to have to change to a different lipid agent, for instance, or things like that.

We were able to secure this really special provision for those medications, because of the sensitive nature of people who have been stable on particular medicines, not having to change and go through that.

There are also several appeals processes that are available to the consumer and their family members. A family member can be involved in this on behalf of an individual who is designated as an authorized representative, which is also important here, and/or the treating physician can appeal. If another medication that a person might need is not on the formulary, other than those three classes of medicine, say a side effect medicine or different things like that, they can appeal to have it

put on the formulary.

You can also appeal the tier of medicine category. These medicines, a strategy of the prescription drug plans in keeping cost down, is to have the medicine on a different co-pay tier. It is a very complicated benefit, and that's probably the hardest thing about the whole thing.

So the duals, otherwise, payment wise, there are three ways you pay for this benefit. The duals will not have to pay a premium, and they will not have to pay a deductible, but they do have a co-pay per prescription that can be between $1 and $3.

MR. KIRK: Is it a fact that the co-pay cannot be, this is federally mandated, cannot be waived? Again, going back to our situation, we have people on average on five medications. Sometimes those prescriptions are for relatively short periods of time, so during the course of a month they might have to be renewed three times because of the severity of the condition.

So that co-pay for these folks may seem like a small piece of change, but it's not a small piece of change.

MS. EVERETT: We're very aware of that. A $3 co-pay, for instance, if the medicine is put on a higher tier, can be a problem, particularly if you multiply that

by five, and you know the realities of living on disability income. That's a very tricky issue also, because the kickback laws involve that.

If there is not the capacity in the federal regulation to waive the co-pay that has to be charged, where that can be waived is at the point of sale at the pharmacy. The pharmacy can decide not to bill for the co-pay. There also can be a system set up where clinics, you know, a person can have a charitable group help them with the co-pay, but it can't be officially waived by the federal government. Neither can a drugstore have an official policy of waiving the co-pay, because that gets into encouraging people to come to a particular drug store and use particular medicines that could be associated with a kickback.

We have really tried to work that out. A number of the pharmacy companies have been interested in setting up opportunities to help offset the co-pay, doing that in a way that is not directly connected with one particular company that might have undue influence on the selection of one or the other of the antipsychotics.

It has been quite a challenge. So that is actively being worked on, but for right now, the co-pay can't be waived. Now, a state can also choose to work with the co-pay through their Medicaid program, but that's very

variable.

MR. KIRK: Yes. In Connecticut, the legislature passed a bill and they have $5 million available for the co-pays. This goes beyond mental health. This is MR, across the board.

Our concern is whether legislators want to do what to do what Connecticut did. In other words, people understand that this is going to be an at-will cost that's going to continue to along. My concern is that somewhere along the line legislators will say, well, we just can't afford this anymore. We either go into the state's pharmacies, or we go ahead and try to supply medications in a different way.

Let me ask one other question, though, and I'll leave you alone. My understanding is that January 1 is the go-live date to put in the plans. I know in Connecticut, Congressman Larson is arguing and supposedly there are other congresspersons of the same orientation that this is just too complicated and the period for getting into this should be extended two years.

Is there any spirit in your understanding to phasing in implementation of this in a slower way than what is being planned?

MS. EVERETT: There is absolutely no spirit to changing anything that I have heard at all. To be honest,

it came up in the wake of Katrina, because that so preoccupied a lot of the energy and efforts of folks at CMS and us in working on sort of responding to that.

Federal questions were raised at that time about delaying the onset. There is no thought at all that they want to delay in any way the onset. The January 1st deadline is a pretty drop dead deadline.

So what happens on January 1st, I think you had asked that question. As of November 15th, so a month ago, individuals can enroll in the program, but no benefits start until January 1st. The big thing for us that happens on January 1st is that that's the date beyond which Medicaid cannot be used to acquire medicines.

MS. SULLIVAN: Medicaid?

MS. EVERETT: Medicaid. If you're dual eligible and you have been previously receiving your medicines through Medicaid, you can no longer do that by federal law, because Medicaid always has to be a payer of last resort.

Yes, you can sign up in advance so that everything is all ready to go. November 15th, that's correct.

MS. SULLIVAN: Yes. I'm sorry.

MS. EVERETT: Any other questions?

DR. GARY: I wanted to ask a question that is a

concern of mine. I hope it's not a real issue, but I have to ask it anyway.

I guess about two months ago, the data were shared, and a report was generated by the National Institute of Mental Health about the efficacy of the atypical antipsychotics when compared to the second generation psychotics. One of the findings was that from a therapeutic perspective, there was little difference.

Now, I'm not discussing some of the issues with the study design, but I am wondering with that particular finding if that would influence policy to the degree that some patients who have done very well on the atypicals, such as olanzipine and risperidone, geodone, et cetera, would be put in the position where the state or federal government would elect to have those drugs on formulary and clinics and hospitals, and not be atypicals? How do you see that impacting the populations across the United States? Do you have any anticipatory kind of policy in place to deal with that? Or is it a problem?

I'm thinking that if olanzipine cost $17 a pill, and you can get Haldol and some of the other drugs for $2 or $3, then that is a tremendous cost savings to the enterprise. With this data from NIMH, I'm just wondering how it's going to influence the policy of some people who really, really watch these data and use it to their

advantage.

Now, the problem is people respond to drugs on an individual basis. Some do well on one drug, and others do well on the other. But the data, we're talking about evidence-based practice. If the data says that there is not much difference and you can save billions of dollars, then where does that leave us with patient care?

MS. EVERETT: That's an excellent question. I do think that particular study, it's called the CATIE study, opens up the door a little bit towards reconsidering the older antipsychotics as legitimate treatment, feasible legitimate treatment. as opposed to only contemporary medications which do have far fewer side effects, and are much better tolerated by most people might be acceptable to use.

That came up almost immediately after the CATIE study was released. The CATIE study was a complicated study, and we won't cover that right now, although I'd be happy to do that at some point if anyone is interested, our perspective on it.

But what was published was only the first phase of the CATIE study, which was interesting for us to keep in mind. So it is very preliminary data. But the way it came out was that the older medicines are just about as good as the newer medicines, at least by patients making decisions

to stay on the medications.

It came up where several of the prescription drugs plans called CMS and wanted to change that so that it didn't have to cover all of the more contemporary medicines. Because remember, we had the antipsychotic medicines that are in that special category that all of them had to be covered for all Medicare recipients or beneficiaries.

So there was sort of an idea that maybe we don't need to have that special requirement that CMS created for those medicines. CMS was very steadfast in defending that no, we're not changing that policy at all, we're keeping it so that individuals have access to all of the new generation or newer antipsychotic medications.

So for now, that has been a very firm opinion of theirs. Over time, that particular provision was not actually written in the act, the federal acts that enabled Medicare. So over time, you're right, that could unravel. I can tell you honestly right now that that is not the intent at all in the Central Office at CMS. But it may be that we need to maintain some vigilance on that in the advocacy communities to assure that that benefit is preserved for individuals over time.

We know we're good for the first several years of the program the way it is set up. So that's important.

I can also tell you that a number of the groups that we work with on a daily basis are very aggressively tracking who is using what medication in these categories of medicines that go along with mental health treatments, the antipsychotics, antidepressants, and the mood stabilizers.

So making sure that people have access to those is a prime concern of a lot of the groups that we're working closely with. So you're right, that's not a guaranteed long-term for the benefit, but for the immediate outroll, the benefit is preserved that individuals will be able to stay on that without hard core, first fail types of procedures.

There is not a first fail allowed say, for instance, to use your example, first fail Haldol or one of the other medicines, to get to olanzipine. Drug companies cannot do that at this point in time, absolutely not. If it happens, that needs to be reported to CMS immediately, or myself, if any one of you is in a position where you see anything like that, because that's not supposed to happen.

DR. GARY: I just wonder if it would be wise to have some kind of fairly aggressive position about it. Just let me tell you why.

Because at one time, I spent most of my life in the State of Florida. At one time, there was specific kinds of guidelines about treatment. People could be

cleansed on the antipsychotics in some facilities, not all, but in some. I was on the Governor's advocacy group, and we effectively lobbied to have that removed, because we thought it was cruel and unnecessary for a person to have to have X numbers of psychotic episodes before they could get to the third generation medications.

So I didn't want us in the name of improving mental health and well being to take any backwards steps. That's something that I'm very concerned about and ask that we put some mechanism in place so that we can track what might be happening, the potential of what can happen to individuals.

MS. EVERETT: That's a very good thought about that. I can think that through and sort of provide a little bit more specific information on what is being done with regards to tracking that.

DR. GARY: That would be good.

MS. SULLIVAN: You know, Anita, I really like to consider myself somewhat of a person who can get my arm around things, and intelligent. But I go to a county health clinic, and there is no way that these people are going to be able to put their hands around prescription Plan D.

If there was just a one-page flyer, just a little folder or brochure that said just like the medical

bill of rights that they have, just like the medical bill of rights that said this is what you're entitled to, this is the co-pay, and maybe it was done by the state with SAMHSA, of saying this is what you need with prescription Plan D, that it's not what the doctor says, and not what the nurse says -- because I tell you, the doctor is going to say ask the nurse, and the nurse is going to say ask the doctor and ask the front desk. No one is going to want to explain this.

I know in my residence there is someone who is actually going to be giving a lecture to the elderly. The city is providing lectures.

I see Carol Burnett on the air, and I don't know if she is being, you know, paid for by an insurance company. I am so confused. If I'm confused, right, I know everyone in my clinic is confused.

There is no way. I mean, I see all of this. You have to go to a website. Well, I know everyone in my clinic doesn't have a computer. I see this as all going inside the system. But if a brochure can be in the clinic, do you know what I mean? Where it's sitting right up there when you go to check in so that people who are disabled know on a date.

I mean, how do we get this just straight out into the hands? Instead of sending it to the providers and

sending it to people, I mean, just right in the hands. The window is so small. I mean, do we have one brochure that tells you, this is what you're entitled to?

In the State of Connecticut, maybe Tom can help me with this. Your co-pays are going to be different, every state is going to be different. Ken, your co-pay is going to be different. Do you know what I mean? Every state is going to be different. This is going to be a NASMHPD issue, right? A NASMHPD issue?

MS. EVERETT: Yes, that's right.

MS. SULLIVAN: So every state and federal is going to have to come up with their co-pay issues. I mean, this is something that everyone has to get their arm around to explain before all these people who are mentally ill and have substance abuse are going to be denied their benefits on disability.

What's the window of opportunity to sign up for D? Nine months?

MR. KIRK: No. A plan is assigned to you if you're dual eligible as of November 1, right? You are automatically enrolled in the plan. And then if you choose, the consumer can choose someplace after that to move to --

MS. SULLIVAN: To D?

MS. EVERETT: The duals can always change.

They're a special enrollment category. Once a month is the way it is operationalized.

MS. SULLIVAN: Yes, I know, but if you are disabled, you have to sign up for D.

MS. EVERETT: Yes.

MS. SULLIVAN: Right.

MS. EVERETT: You have to sign up for it, unless you're dually eligible. They are automatically enrolled.

MS. SULLIVAN: Okay. But if you're mentally ill, you have to sign up for D?

MS. EVERETT: Unless you had Medicaid before.

MS. SULLIVAN: Right.

MS. EVERETT: In which case you'll be automatically signed up. You can change, but you'll be automatically signed up.

MS. SULLIVAN: This is just like way beyond me. I mean, and these people that are walking in there just have no clue. You know, even people who you see on these ads, can there be one brochure for every state?

Can Steve Mayberg put one out? Ken, whoever is replacing you? I want to hear your reaction. I'd love to hear, Tom, your reaction, before I see people in a year and a half and they realize it's gone, you know?

MS. EVERETT: I mean, there are a couple of

things that I can tell you that we've done to help with that a little bit, realizing that this is an extremely complex benefit, to do what we can to also make sure that the case manager or someone in that function for someone who could help traverse this. They may have a case load of 50 to 60 or maybe 100 or so individuals, some of whom would be eligible for this, that that individual can kind of help sort out and understand the benefit.

MS. SULLIVAN: But the nurses don't understand it, and I know some of the shrinks don't understand it. You know what I mean? I mean, I know when I ask them, they don't. That's why the cities are now holding these conferences, but you have to be mobile, you have to have bus fare to get to these things. You have to have babysitters to get to these things. We're talking about indigents and the very poor who don't even know that the cities are holding these conferences.

It is this Catch-22, and the bottom that need this information most, or sometimes the illiterate need it.

MS. EVERETT: Right.

MS. SULLIVAN: I mean, this is something that is going to hurt the very, very poor. How do we help these people before they fall through the cracks? And that's the point of this prescription drug plan.

MS. EVERETT: Right, right. I mean, one of the

things that actually will, at this point in the benefit, the duals, people who have both Medicaid and Medicare, the most poor individuals, have been automatically signed up.

One of the things that is a simple place to start is to look at the program that that individual has been signed up for and see what is available.

MS. SULLIVAN: One of the things is to look at it. Who is to look at? This is extremely frustrating. Should someone get to the table and say, we need to extend, like Tom said, this window. Maybe it's Charlie, and maybe other people at HHS have to say, we have to extend this window to really see this window of opportunity, extend this window before people fall through the cracks.

I mean, we need to really look at this and say oh, we've drawn this line too short. I know we have a very small window to talk about this today, but this is so important, that maybe we should hold this over for more discussion about this on the table in April or May, because this is just so important with so many people falling through the cracks. If you put this on your national calendar, I'm sure this is.

MR. KIRK: Just real quick. Different states are trying to educate the consumers in different ways. One of the things that we found is that we do these mass kinds of things, websites and all those kinds of things. The

persons that we're most concerned about are dual eligibles.

So you've got to get to the case manager that sees this person three, four, five days a week. That's the one that's sitting there, and they need to understand the plan. NASMHPD has been very aggressive in tracking this. For those that are interested, Bob Glover, who is the Executive Director, in one of the briefing pieces shows the things that they're doing.

I think the message, at least from my point of view, is this just has to be something that we track. It has to be tracked probably more so post-1/1 when the key is turned, that you can discuss different ways to educate. There are lots of different ways that are being used around the country. But when all is said and done, Joe Smith is going to go on some sort of plan on January 1st, and he's going to be on five plans, and some of them are going to work, and some are not going to work. That's what I'm concerned about. That's what needs to be tracked.

MS. EVERETT: Certainly that's true, but we can set up something for follow-up on this. I wanted to hear from this side of the table quickly, and I am getting signals that our time is running out.

MS. VAUGHN: Ken Stark?

MR. STARK: I agree with everything everybody said. It is confusing, and states are doing a number of

different things, the Medicaid offices, the mental health offices, the alcohol and drug offices.

I agree with what Tom just said in terms of the tracking, but the tracking has got to be twofold. The issue of eligibility and access are always two different things. I have seen many, many times where in both private sector and public sector, we have contracted with entities, we have put all this stuff in there that folks are eligible for, but that doesn't necessarily mean they get access.

So if we're going to track, we need to track not only the transition as to all the enrollees and did that part go smooth, but we need to track the issue that Tom Kirk brought up about are folks going to be able to get access to those medications, or are we going to run into scenarios where the plans using their medical directors or their other gatekeepers going to transition people off of certain medications to others under the guise of studies that show cost effectiveness, cost efficiencies.

So I'm hopeful that SAMHSA working with CMS is going to look at a tracking system, both relative to the enrollee side, as well as relative to the access side and transitions that are caused by the plans once folks get on them.

MS. EVERETT: I appreciate that comment. We are very actively involved in that, but I think also some

way to create feedback from each of you who are in positions to see how this plays out more locally would be very helpful for me and SAMHSA in the process of doing this. So some follow-up on this I think is a good idea.

MS. KADE: What we'll do is we'll continue the dialogue for about five minutes. I just checked with Andy and Toian. What we'll do is we'll relay the dialogue back to Mr. Curie and talk about a follow-up conference call or an April agenda item. But we'll make him aware of the issues.

MS. VAUGHN: Gwynneth or Barbara, did you have a comment?

MS. DIETER: I mean, I'm not particularly knowledgeable, but from the consumer viewpoint, the idea that each case worker is going to have the information that you have seems impossible to me.

I mean, you're doing a great job. I feel a lot of sympathy for you, because you understand that it has been given to you, but to deliver the information about how it works to the people that need it seems to be impossible.

The only thing would be, from my viewpoint, would be what Kathleen suggested, which would be in each county or state or whatever to try to actually define on a short, two pieces of paper, as best you can what needs to be done, and send that out to everyone. Then obviously

give them numbers so that they can call you.

They are going to end up spending more money tracking what isn't being done than the money we're saving to begin with. I don't know. It is very difficult. It's great that you have understood all this and can do it, but I just don't see it working.

MS. EVERETT: I think by April, if that's the time frame, we'll have a lot more information. It depends on how much time we want to take. It sounds like there is a lot of interest here. We could certainly have some of our friends from CMS come over and do a more formal presentation. By April, we should know a little bit about information for dually eligible individuals that are automatically enrolled.

The worst thing that can happen to them is they could be signed up to a program that has less favorable co-pays. But basically they are protected, and should be able to access their medicine. That being of the most concern.

If they are assigned to a plan that they don't want to be in, they can change every month. So we can worry about them, but only so much immediately in January. The people that stand to benefit the most from this are people that probably don't have much access to meds right now, these middle income people, lowish income. There are about 8 million of them.

CMS is all over tracking them and doing whatever we can to make sure that those people sign up, because they are not automatically signed up. They had to actively do that. Information has been mailed to them and things like that, but this is a very transient population.

MS. DIETER: Yes. I hear what you're saying.

MS. EVERETT: Right. That could fit for those 8 million if they are not also falling into the Medicaid category. They are not automatically signed up. I'm maybe getting into too much detail.

MS. HUFF: I just wanted to mention that I'm the former director at the Federation of Families for Children's Mental Health. I noticed on your list of people that you informed and did workshops with and that sort of thing, they weren't on there. There are a lot of grandparents raising grandchildren, grandparents having mental health problems, and parents raising children who have mental health problems, and just because it's a children's organization, children's mental health organization, I wouldn't not educate them in the same way you've educated NAMI and some of the other organizations to understand.

MS. EVERETT: Sure.

MS. HUFF: And I also understand for the carrier of the message, and we're kind of beating you up a

little bit about this, and I don't want you to feel that way, even though if I were standing in your shoes, I would be feeling that way.

I am willing to turn it over to Faye at this moment, but I just wanted you to consider allowing those other organizations the same opportunity.

MS. EVERETT: That might be a good idea. A lot of that, the Area Agencies on Aging have a lot to do with dissemination. Eighty-five percent of the Medicare recipient population that are aging, you know, are Medicare recipients because they're aging, so that's one avenue.

Folks from that organization, they don't know that. I think it's very worth me trying to contact them and set up something with their leadership to see if they have any questions, or how we can help them with that. I think that's a great idea.

MS. HUFF: I'd be happy to make that (inaudible).

MS. EVERETT: That would be great.

MS. HUFF: Also there are some other (inaudible).

MS. EVERETT: Great.

MS. KADE: I think we'll have one more speaker. Faye?

DR. GARY: I'll make this very quick. I wanted

to get back to the model that Tom and Ken had begun to lay out. One talked about eligibility and the other talked about access.

I wanted to add to that model treatment to also say that when we begin to look at this, that we somehow track the quality of treatment. Perhaps one of the advantages of the atypicals is fewer side effects, fewer movement disorders like tardive dyskinesia, et cetera.

I think we should begin now to think about policy that states that when patients come in for renewal of medications, there will be a systematic assessment of the movement disorders and other side effects that might be associated with the change of their drug regimens from the second generation to the atypicals, which is the third generation drug.

MS. EVERETT: Thank you very much for that comment. That reminds me of one of our sort of highest priorities, which is providing consumer choice. I think that's correct, yes.

MS. KADE: So what we'll do is we're going to review the minutes of the meeting and identify a list of issues that have been identified.

What I will do is talk to Mr. Curie and see whether or not we could arrange a conference call before our next meeting. Our next meeting is actually scheduled

in June. So before June if we could get some representatives from CMS on a conference call with the members to go over the issues that have been raised, we will try and do that, and we will get back to you.

MS. EVERETT: Thank you very much.

MS. KADE: Thank you, Anita.

We're running a little late, but our next agenda item is on underage drinking. I have the remarks that Charlie was going to read to you. I'm going to read them to you because I think it's important to get some context, and then quickly move onto our speakers.

Charlie wanted to move directly to this item this morning, which we intercepted with this dialogue on Medicare. Steve Wing, the Associate Administrator for Alcohol Prevention, and rather than Mark Weber, we have his representative to make a brief presentation as well.

Yesterday Mr. Curie talked briefly about the need for SAMHSA to do more as an agency to help prevent underage drinking. He also mentioned that we were not doing enough together as a nation, and that it's very challenging.

Secretary Leavitt called the Interagency Coordinating Committee on the Prevention of Underage Drinking to convene a national meeting. As chair of the meeting, Mr. Curie has assured this committee that each

member of the committee is deeply committed to turning words to action. Each is committed to working closely with each other across departments and agencies to get the job done.

In fact, the Surgeon General, Dr. Richard Carmona, who is a member of the committee, announced his intention to launch a first-ever Call to Action on the prevention of underage drinking during the second day of the meeting.

The committee also includes representatives from the Departments of Health and Human Services, Education, Justice, Transportation, the Office of National Drug Control Policy, Department of Defense, the Department of Treasury, and ex officio representation from the Federal Trade Commission.

On October 31st, Secretary Leavitt opened the meeting, which had an unprecedented roster of leaders and top level state delegations and attendees from across the country. The Secretary called on each governor to assemble a team of experts in their respected state. Each governor responded, and teams were sent from every state and several territories of the District of Columbia, with the exception of the state teams from the Gulf Coast region, which we are organizing a follow-up meeting for.

The meeting was about finding the common ground

to save lives. In short, the meeting was about turning words into action. Our nation has acted on preventing drug use. The result is that teen use is down. We have acted on preventing tobacco use by young people, and the result is teen tobacco use is down. Yes, underage drinking remains a serious, persistent, and stubborn problem.

Alcohol is the most widely used substance of abuse among America's youth. A higher percentage of youth age 12 to 20 use alcohol than use tobacco or illicit drugs. Underage drinking is a leading public health problem in this country. We are about to establish federal goals for reducing underage drinking. Building accountability, we have set measurable targets for reducing the prevalence of underage alcohol use, reducing binge alcohol use, and increasing the age of first use.

We can and must meet these targets. It is time to get real focused and push back. For too long, underage drinking has been accepted as a rite of passage in this country. Far too many young people, their friends and families have paid the price.

Let's change attitudes towards teen drinking from acceptance to abstinence, and recognize the importance of parents talking to their children early and often about alcohol, especially before they start drinking. We must replace an environment that all too often enables underage

alcohol use with an environment that discourages it.

It is clear that our greatest chance of success depends on our ability to achieve a comprehensive, national approach to preventing and reducing underage drinking.

Steve Wing will now share a few details of SAMHSA's and the Interagency Coordinating Committee's role in moving that process ahead.

Steve?

MR. WING: Thanks. We have a list of SAMHSA's underage drinking activities on their way. We had a little glitch, so you'll get them in a few minutes, and I'll speak from my notes until you do.

There are eight main activities, some of which Daryl has already mentioned that we're involved in. The first, as Daryl mentioned, is the Interagency Coordinating Committee that Mr. Curie chairs. That's been in place for a year and a half and will be a standing committee. It serves to try to coordinate federal activities.

The second is the SPF SIGs, which you heard about yesterday. Third is Reach Out Now and the teach-ins. Fourth is the national meeting, the town hall meetings. Sixth, the website. Seventh, report to Congress, and finally the Ad Council.

I'm not going to say a lot about any of these because of the time constraints, but I'm going to defer

completely on the Ad Council campaign to my colleague, Alvera Stern. There's no point in my covering it as well.

I have already talked a little bit about the Interagency Coordinating Committee. As I said, that's a standing committee. Yesterday you heard about the Strategic Prevention Framework State Incentive Grants, the SPF SIGs. They have an emphasis on underage drinking. I don't really have a lot to add, except to make the point that they are expected to make a significant impact on underage drinking by making it far more likely that the prevention systems address this important issue.

There has been a heavy emphasis on preventing illicit drug use. I think that folks have often forgotten that alcohol is the substance of choice for America's youth, that a higher percentage of youth age 12 to 20 use alcohol than use tobacco or illicit drugs, making underage drinking the leading public health problem.

The Reach Out Now campaign and the teach-ins are something that we have been doing for a number of years now. That's a SAMHSA project in collaboration with Scholastic magazine. We do underage drinking prevention materials for fifth and sixth graders and their parents. Those materials are sent to every classroom in the United States, public, private, and parochial. Each classroom gets 30 copies of the parent's section, so kids can bring

them home from class and talk to their parents about them.

One of the little twists to that is something we call the teach-ins. They were started by Hope Taft, who has been very involved in the prevention of underage alcohol use for years. Ms. Taft suggested when this program began that it might be good to draw attention to it by having someone prominent in the community teach the materials in a fifth grade classroom with the hope of getting press coverage and draw attention to the issue.

She was somehow able to convince the governor of Ohio to do that, and he did. That started teach-ins across the country. We do that every year, and we will be doing it again this year. It is one of the SAMHSA signature programs. If you want more information, there's a website. It is teachin.samhsa.gov. Teachin is all one word. That gives you information both on the teach-ins, and on the Reach Out Now materials.

Daryl has already talked about the national meeting that was convened at the end of October and early November. Three hundred twenty four team members attended. They were from all states in the country, with the exception of people from the Gulf States that couldn't come because of Katrina. There were an additional 88 observers representing public health groups, advocacy groups, and the alcohol beverage industry.

That meeting included a speech by the Secretary, Mr. Curie was the host, panelists, very distinguished researchers in the field, state panels talking about what states have done, and concluded with the Surgeon General announcing that he was going to do a Call to Action on underage drinking.

That meeting, we have gotten very positive feedback on. When you hold those meetings, you want to have something that people can go home and do next. Because if you don't, they just kind of float off, and everybody has an interesting time.

So as a follow-up to that, we asked each state team to join with us in promoting town hall meetings on underage drinking across the United States in March of 2006. I'm not going to take the time to go through all the details on the town hall meetings. I have given you a little two-page write-up, a Q and A form, that goes over what we're looking for.

This is a joint activity between SAMHSA and the Interagency Coordinating Committee on the Prevention of Underage Drinking. So all of the agencies involved will be helping with this. SAMHSA, however, is stepping up to the plate by providing $1,000 to each of the 1,500 communities across the country. It's not enough to open a whole coalition, but it is enough to help a coalition with some

of the costs to hold a town hall meeting. This two-page Q and A will give you some of the details about what we're expecting and hoping to achieve.

Those meetings, the communities that are going to receive the stipends in each state will be selected by the state teams that attended the meeting earlier this fall. So we're asking the teams to kind of get together and find communities that they think would do a good job. The overall goal here is to try to get some national momentum behind looking at this issue. One of our problems, which you'll hear more about from Alvera, is that most parents do not see this as a serious problem.

One of the reasons is that they don't understand a lot of the research that has come out in the last ten years that show that there are not only the short-term consequences of underage drinking which we all know about, the risk of injury, death from drunk driving and that sort of thing, but there are also some long-term consequences, such as the increased likelihood of having an alcohol problem later in life.

Another thing that we've done through the Interagency Committee with SAMHSA's support is a website called stopalcoholabuse.gov. That's an all government site where people can get access to information about underage drinking from all the federal agencies.

You might want to, if this is an issue you're interested in, you might want to take a look at that website. We had some of the materials from the underage drinking in place several weeks ago, including a link to NIAAA. They have a new publication out that summarizes their research on all the areas related to underage drinking, the epidemiology, as well as the consequences.

There is a report to Congress, the first annual report on underage drinking that SAMHSA and ICCPUD developed. I can't tell you much more about it. It is there, and that contains the goals that Daryl mentioned.

That leads me to the Ad Council campaign. I'm going to turn it over to Alvera Stern at this point. You'll find this very interesting.

DR. STERN: Hello, everybody. I'm going to go over very, very briefly the background to the Ad Council Underage Drinking Prevention Program, and then talk very briefly about some of the research, show you the PSAs, and then talk briefly about the next steps.

We did a fairly extensive review of the research, and in fact got about 250 germane articles, two volumes that any of you who are interested may look at, and much of the research was from SAMHSA, NIAAA, the AMA, and our friends across the nation.

We found out, first of all, that about 29

percent of underage people, 12 to 20, reported current, that is monthly, alcohol use. Of those, about 40 percent were 12 to 17. We also know from the research that the number of deaths for underage kids caused by alcohol is 6.5 times more than the deaths from all other illegal drugs combined.

We found also that kids who begin drinking alcohol before the age of 15 are five times more likely to develop alcohol problems than those who start after the age of 21. That was an '03 study from NSDUH. Joe Gfroerer in OAS tells me that that percentage, that five times, is probably a little higher in the newer data.

Many kids in this country start lifetime use around 11 or 12. Between 12 and 15, that percentage of kids using goes up fairly dramatically, a mathematical progression. We also know that of people in treatment, alcohol-dependent adults, about 95 percent say that they started drinking, they had their first drink before the age of 21.

In our research of parents of which we just pulled out, of course you know there is an enormous amount of research here. Most kids say it's easy to obtain alcohol, and it is very easy to get it from their homes.

In studies by NIAAA and others, we have known for some time that the protective factors from parents are

very, very significant. Kids are much less likely to drink if their parents are bonded with them, if their parents have conversations with them, if their parents have neither very, very, very rigid rules, nor very, very, very loose rules, but have a rubber band approach to parenting where the kids know the boundaries, and the boundaries change as the kids get older.

We found out that parents do know that they have influence. They don't know how much influence they have, and very often they underestimate the influence. They have difficulties knowing quite what to say to their kids about the subject.

From this early research, we made the objective to encourage parents to speak with their children early and often, with two goals in mind. To delay the onset of underage drinking, and to ultimately reduce underage drinking.

After this literature research, we went to the parents and the kids themselves, and we did focus groups in various areas of the country with various different types of parents and their children. What we found is that most parents felt there were other issues that were much more critical than underage drinking.

Drug use, much more critical, sexual activity, much more critical in their eyes. Parents generally

thought it was other kids drinking, not their kids. There was a lot of denial in all the focus groups. Their kids simply weren't part of the large percentages we quoted to them. They simply did not believe that drinking could possibly start in middle school.

We also had a very interesting happening at the same time. We were working with the ad agency Kaplan Thaler. A bunch of 30-somethings, early 40-somethings that didn't believe the research either, because they all had kids in this age group. There were many conversations that happened after our meetings with the ad agency personnel as they went home and talked to their kids and said, I just don't believe this.

The parents were concerned about safety issues, if they were concerned about underage drinking. They talked a lot about the dangers of drunk driving. But they said, you know, we did it, it's not a big deal as long as the kids drink at home or drink in moderation, it's fine.

After this research, oh, one more thing. We went over the statistics, some that I showed you, and others, to see what parents resonated with. There was really only one statistic that made them sit up and take notice. That is the statistic that if kids start drinking before the age of 15, they are five times more likely to be alcohol-dependent after 21.

From this focus group, we chose our target audience, parents with kids age 11 to 15, targeting parents of kids in early middle school. Kids who have started not yet drinking. The key message we wanted to get through to parents was the chances of the young person developing an alcohol problem increases the earlier the child starts drinking. With the go-home message, the action message, of start talking with your kids before they start drinking.

(PSA shown.)

DR. STERN: There are some radio ads, two printouts, and you'll see them on either side of the podium there.

We have packaged these, and they are on your table. We can mail them to you. If you open the package, inside are the print copies and a little fact sheet. Now, we are going to make these available starting with training for the town meetings. The first two trainings, one is in Boston, one is in Reno, at the end of January. We'll be training prevention people in the regions to organize town meetings, and also get hold of the PSAs and go down to the local media and get them on the air, radio, and print.

So we are printing community kits that will be a little flatter than this, because they'll have CDs instead of the VHS tapes. Those will go across the country. The media were mailed these kits last week, and

we're expecting to start them playing probably in a week, or two, or three, and definitely in January.

We're also going to make sure that in the Scholastic handouts to all teachers, fifth and six grade, this work is highlighted, and parents are directed to the stopalcoholabuse.gov. On stopalcoholabuse.gov, you can click on the PSA and then go to a website for families that talks about alcohol abuse and its prevention.

So questions for Steve and I?

MS. RACICOT: I want to know, are you buying time? Or are they all PSAs? Even when you send these out to the press, are we purchasing air time?

MR. WING: No, we're not buying time.

MS. RACICOT: So we don't have a lot of guarantees that they're going to be willing to run them?

MR. WING: Well, we're hopeful.

DR. STERN: Let me just say something about that. These were from ONDCP and they were accepted, which means that they will get much higher play time because, as you know, ONDCP buys the time for drug ads, but when the station buys time to use the drug ad, they have to promise to do a match time for another set of ads, and there are only a very few set of ads that qualify for the match.

MS. RACICOT: What has been the industry response? Do you know? Have you gotten any from them?

DR. STERN: Yes. We heard from the Beer Industry Executive Council, Coors, and of course our advocates. We worked with the industry. The legislation that earmarked this money for the Ad Council said that we must do this in consultation with the industry. So we have had two meetings with the industry and advocates that were public and organized ahead of time.

Then Steve has done quite a bit of talking with the industry. I have done that in consultation with the Ad Council. These ads, they have been well received by CSPI also.

MR. WING: It was sort of interesting, actually, this happened actually that the advocacy groups and the industry groups jointly signed the letter to Congress requesting that the Ad Council campaign be funded this year. That was surprising.

The only other thing I'd add is that this campaign tracks closely recommendations from the Institute of Medicine's report on underage drinking several years ago that recommended that we target parents, that there wasn't enough evidence for targeting children.

DR. STERN: The other thing, I just got a note from someone suggesting that I mention that these ads just won a very prestigious Silver Bill Award. The Ad Council takes all of its campaigns every year and sends them out to

the ad agencies that do creative work, and those peers vote on the best ad campaigns of the year.

The Ad Council this year had 80 campaigns, 8-0. The peers voted this the best.

(Applause.)

MR. STARK: I was just going to make sort of a comment that it is nice to see that alcohol is getting play time on the federal agenda now, more so than it did awhile back, and it needs to, especially given all the statistics that are pretty obvious.

But it is sad to hear that the alcohol and beverage industry still seems to somehow have an impact on the federal budget not buying time for these ads. That's an opinion, and I'm free to give it. I'll continue to state that. It's an historical problem. I think everybody who works in the alcohol/drug field knows.

It would certainly be nice to see more dollars appropriated to actually purchase time on the alcohol side of these ads, and not just the drug side. Especially given the fact that it is the number one killer drug.

MS. DIETER: I agree. I mean, I would like to see this ad on ten times a day everywhere. I actually didn't realize that the federal government didn't pay for ads against the use of alcohol. That's shocking.

MS. HUFF: You kind of answered it and kind of

didn't, but I was just wondering why it was important that we had adopted the industry's collaborative effort on this.

MR. WING: Well, we were directed to do it by Congress.

MS. HUFF: I got that.

MR. WING: It was a condition of the funding.

Kathleen?

MS. SULLIVAN: I emailed Tom. I think I emailed you and everyone on the council about a New York Times piece where the alcohol companies were actually targeting young drinkers in the guise of doing these kind of promotions, you know, little parties, but it was aimed at binge drinking.

I think, Tom, you emailed me back that you had some success at the state level of nipping it in the bud. This gives us an opportunity to at least talk about it.

MR. KIRK: I wish that was my response. I think the reality was that when I spoke to my prevention people, they were aware of some of these kinds of activities going on, but the article basically was that particularly college settings, binge drinking was some sort of game where you throw something and then you drink.

I think my comfort was that within some work that we are doing with all of the community colleges and state colleges in Connecticut, this is one of the focuses.

We haven't seen yet what the outcome of that is.

MS. SULLIVAN: Even because it's becoming such a social, binge drinking is becoming such a hit thing, with young kids even seeing it, I mean, I just wanted to bring that up, as we talked about binge drinking before. It's just so popular on campuses.

MR. WING: I think you're talking about the beer bong or something like that.

MS. SULLIVAN: Yes.

MR. WING: My understanding is that lot of the support for that has been withdrawn as a result of public pressure.

MS. SULLIVAN: Yes, yes, exactly.

MS. RACICOT: I want to say one thing about the advertising. The Internet is a disaster. They have all kinds of kids video games buying beer at websites that lure the kids in to play some little car racing game, and then get into Bud Lite, Miller, and all the rest of them.

The advertising is unbelievable, and I think basically we as Americans and parents are totally unaware of it. I don't know if any of you have seen CAMY's presentation on alcohol advertising. It will make your hair stand right on end.

Our kids are so exposed to alcohol in their lives from the time they're this age on up. I frankly

can't imagine anything else in this country that we would be screaming from the rooftops about, lead in our paint, lead in our water, we can't do anything now without a car seat that costs $250 in this country. And yet we expose our children every day to the worst poison in their lives, and we do it because it's a legal substance that makes money, and because of power lobby.

I'm free to say this. Frankly, I think it's the truth, and until we address this as a country and a culture, we're still going to have the number one drug that our children get every day. I mean, I saw a young girl, 22 years old, who is a meth addict who has been clean for four years.

She stood in front of a group at a press conference, and she said, I started at 14 with alcohol. At 15, I was smoking pot, at 16 I was raped. At 17, I started meth, and for the next nine months, I spent every day trying to do what I could do to get it. She said, my parents, God bless them, mortgaged their house and practically sold their lives to put me in treatment. She said, I'm 22 years old today, I started college, and there's not one day I don't wish I could use this drug. She started with alcohol.

We are naive if we don't believe it's the gateway to what is destroying people's lives. There is a

lot of proof now that you can have alcohol problems the rest of your life by 15 to 18 years old. This is no longer a disease that you get by the time you're 40. You get this young. It starts young, and it destroys your life.

The other thing I want to say, and then I'm done. This is my soap box, in case you haven't noticed. The other thing I want to say is if you have a child that has a problem with alcohol, don't think you can't talk about it. That is when you need to get up and talk about it.

Kids make choices that destroy their lives. It is not a shame on you as a parent. Parents need help, they need empowerment. If your kid screws up, tell other people and give them some courage to start looking at their own kids. I say that as a parent who has walked this road. I know.

The Surgeon General's report was on the table four years ago. The Surgeon General's Call to Action, and somehow it fell off. I am so grateful that it's going to be done today. This nation still responds to doctors speaking. When the Surgeon General, the nation's doctor, says we need to look at childhood and underage drinking, it's going to carry power. It did with tobacco. Thank God it's going to happen, and I hope it's an incredible piece.

MR. WING: Thank you.

I think, Ms. Sullivan, you had something.

MS. SULLIVAN: When did the FCC change the rules allowing advertising, liquor advertising, back on the air?

MR. WING: I don't think they have changed.

MS. SULLIVAN: Oh, you betcha.

MR. WING: Not in the last year, though.

MS. SULLIVAN: I mean, I see liquor ads constantly on television now. I mean, at least on the cable networks which, as far as I'm concerned, are basically the same. I wonder if there is a study that shows the pervasiveness, if that indeed is the reason for the increase of teen drinking. If there is a parallel of teen drinking increase to the frequency of advertising on television. If that is the parallel increase, who should do that study?

MR. WING: There are studies right now. Ms. Racicot mentioned CAMY, which has some very interesting stuff on their website. It is camy.org.

However, I must tell you that NIAAA, which is the custodian of science on this, has concluded as recently as two months ago that the evidence is inconclusive on that subject. That's the basis for which we and the FCC and everybody has to proceed.

Also, the IOM report concluded that the science

-- now this was several years ago, but the science was sufficiently inconclusive. There was not sufficient evidence to allow them to recommend that it override the constitutional protections on free speech. The chair of that was a constitutional scholar.

So that's my best understanding of what the experts and the scientists are saying. Now, that may change over the next year, because there are a number of studies that are out. That's where we are right now.

MS. DIETER: I just want to support what Theresa said. I just agree with you 100 percent. It has been a passion for me since before this all began for various reasons.

I want to say the ads that you created are wonderful, particularly because they address two things that I think are so important. I think that most parents still do not know that the young age of initiation of drugs has these dire consequences. That's a piece of information, and that's what you're giving them.

Number two, they don't know that there is anything they can do about it. I was totally surprised with the first drug use report, or whichever study it was about three years ago when I first saw it that you had a basically 30 percent greater chance of not developing an addiction if your parents talked about not drinking and not

using alcohol.

I thought, my gosh, I know I can think of 100 people I know who would love to know that something they were saying and starting young could actually make a big difference. I think alcohol is accepted, it's not considered a drug in our society.

They think it's the norm, and what can I do? What can I do? Well, just knowing that conversation is huge. So I thank you for doing the ad. I didn't realize the federal government couldn't pay for these ads.

MR. WING: Well, I don't think it's a matter of whether we can pay for them. It's a matter of whether the money is appropriated.

MS. DIETER: Yes. That it hasn't been appropriated. I guess we should work to have that appropriated, because I think it's just shocking.

MR. WING: What you just said is reinforced through the focus groups that Alvera mentioned, that the Ad Council did with the parents. They didn't think their kids were doing it. They didn't see it as much of an issue, as long as they weren't drinking and driving.

They were very surprised to hear that there might be permanent damage, that if they started drinking young, that they were more likely to have an alcohol problem later in life. Which is, as Alvera said, why those

ads zeroed right in on that.

We are hoping that those ads will provoke a lot of discussion in a lot of homes around the country. We're also hoping that these town hall meetings, one of the things we're really hoping is that the communities that are involved with the town hall meetings will encourage their local media to run the ads.

MS. HUFF: You know, my daughter went on a skiing trip when she was about 13, and her room was such a disaster, I decided to clean it while she was gone. I found wrapped in a baby doll blanket in the baby doll buggy with the baby dolls a bottle of whiskey. Of course I was shocked.

To make a very long story short, she was addicted to cocaine by the time she was 18, and by the time she was 19, she was selling cocaine. By the time she was 20, she was selling her body.

So I'm sitting here like many of us, living proof of all of this. Who would have ever known at 13 years old wrapped up in a baby blanket was this bottle of whiskey which would have impacted the rest of her days.

MR. WING: Right.

MS. HUFF: But it is a shameful thing to talk about. I mean, I was ready when she got home from that skiing trip with every bone in my body quivering. I might

not have ever gone to clean that room.

Even though I did, the outcome was not good. What I didn't know is what we just saw, is that I didn't know to compare later, and I didn't know the signs then of cocaine, I didn't know the signs of anything.

MS. DIETER: Or to talk about it before she was 13.

MS. HUFF: Or to talk about it before she was 13. For God's sake, she was still playing with dolls.

MR. WING: Well, certainly the alcohol data embedded in our society is not new. That goes back to, it actually goes back to the Greek, and I won't bore you with that. But it is at least 2,500 years.

That said, we do know so much more now than we did 10 years ago, the science and the impact on the young. I think we can probably start to draw some parent's attention to it. So I am hopeful of that.

DR. GARY: I just wanted to say, too, that I am most appreciative for the ads. I think they are very excellent.

I wanted to get back to the comment that Theresa made, and also emphasize the teach-ins and the teach-outs at school, and bring to our attention, too, that some parents don't have the capacity to teach their children. Some parents are alcoholics and will not teach

their children because it's an interception of their own behaviors. So we know that that is not going to happen.

Some families don't have the capacity to teach their children. Some families don't think they have the self-efficacy to do it. For those families, I think we could come back and focus on what happens in the schools. It seems to me you have a very solid structure set up for the schools, and the teach-ins and the reach-outs in the school.

So I would like to know more about that effort, and also to ask if you have in place any mechanism whereby you can be able to discuss and describe the impact that the teach-ins and the reach-outs will have on children in the schools.

I think if you don't, a large percentage of children will fall through the slats simply because they don't have the structure at home to implement what you wish you had with the parents teaching the children. So I'd like us to focus on that population of children, too, and to ask if there is a second tier to coordinate those efforts, which I think are excellent.

MR. WING: Well, a couple of points. First of all, the Scholastic magazine has done some evaluation, and has found the materials to be very well received.

That said, we know that they are not as broadly

used as we would hope. There are many school systems where they are used, and there are other places where they end up on a shelf. So one of our challenges is to try to make sure that they are more properly used.

We don't have, beyond that sort of evaluation, the kind of fine-grained evaluation that would allow us to know what you're talking about. But I think it's an excellent point.

This note says thank you and good night.

(Laughter.)

MR. WING: As it turns out, I have to leave anyway, because we have a meeting at 11:00 at the Surgeon General's Office on the Call to Action.

MS. DIETER: Can I ask you just one quick thing while you're leaving? Since that fifth grade Scholastic magazine information was so very successful, had such a great response, why don't we do something again in 8th grade and in 10th grade?

PARTICIPANT: We don't teach (inaudible).

MS. DIETER: Yes.

MR. WING: Well, we started with the 5th graders.

MS. DIETER: I recommend that they follow it up two more times or more.

MR. WING: Right. We started with 5th grade,

we have moved to 6th, but we'll certainly bring that back to Mr. Curie. No, I agree.

MS. DIETER: I thought about it a lot before this.

MR. WING: Well, we all know about DARE. It was a one-shot thing and it didn't do much good, but the studies seem to suggest that it may actually have some effect.

MS. KADE: Thank you very much.

So I'd like for us to move to our next agenda item on the National Child Traumatic Stress Initiative Program. Sybil Goldman will be giving an overview, and then we have several presenters. Thank you.

MS. GOLDMAN: I have to say, I found that discussion very interesting. As the children and families person at SAMHSA, there is a lot of very exciting things going on in this agency that do provide a lot of services and information in treatment and early intervention. That's a very important initiative.

I work closely with Steve, because he's really the person who is the point person for us on underage drinking.

I'm delighted to be here with you at council this morning. At your request, we wanted to highlight some of the programs that SAMHSA funds and provides in

communities. There are effective programs that work with children and their families. So that's what we're going to do today, put the spotlight on the National Child Traumatic Stress Initiative, which is really an extraordinary resource that we have in this agency, for the work that it does across the country.

The network develops effective approaches for treating trauma and people exposed to trauma, disseminating information about those approaches, providing training, and providing direct services in communities.

I don't know whether yesterday Charlie talked about this, but the Department of Education, the Secretary of Education, Margaret Spellings, asked SAMHSA to join forces with them in working with schools across the Gulf area that had been impacted by Hurricanes Katrina and Rita, and they asked if we would bring our child trauma experts along with us to work directly with those principals and with those teachers around the children in the communities that had been impacted by the hurricanes.

They were extraordinarily effective, and they're very appreciative, because those schools had access to some of the best experts in the country with some of the things that they were experiencing not only with the children, but what we found out with the parents as well. So just one of the many ways that this initiative provides

support across country.

I'm just going to take a very few minutes to provide a context for our speakers this morning that focuses really on them and what they are doing in communities, and then to give you a chance to have some discussion.

I also wanted to mention that the National Child Traumatic Stress Initiative is headed up by Seth Hassett, who is the chief of the Emergency Mental Health and Traumatic Stress Services Branch at the Center for Mental Health Services. Seth has been doing a lot of work with his team in the Gulf Region.

Dr. Cecilia Casale is behind me and Dr. Malcolm Gordon, as well as some other members of the branch, will be here today to also help answer any questions you might have in discussion.

I'm just going to skip over these slides quickly.

This gives you, and actually it's a little hard to see, I realize, but this gives you a picture of where our grant sites are for this network. They are spread across the country.

What the little grid at the bottom talks about, and I'll give you a little bit more information about this, is that there are really three categories of grants to this

initiative. One is the National Resource Center, and that's actually a collaboration between UCLA and Duke, and then there are what we call the Category II sites, which are the -- I always get these confused here. These are the treatment and service adaptation sites. Again, I'll talk a little bit more about that. Then there are the Category III sites which are the community services sites. It gives you a picture of how we cut across the nation.

So there are these three funding categories. This is approximately a $25 million initiative. This has congressional support, it's actually a congressional initiative. We are very excited that it's here at SAMHSA.

The goals are to improve the quality, treatment, and services for children, adolescents, and parents who have experienced trauma, and to increase access to quality trauma services.

I think what is unique about this is that it really does look at all aspects of trauma. So I just gave you an example about our work with natural disasters. The trauma initiative was very engaged after 9/11 around terrorism, but you'll hear today that there are multiple kinds of trauma that the centers are dealing with and providing effective treatment approaches for. Physical abuse, sexual abuse, domestic violence, community violence, from accidents and from medical conditions. So it's a

broad array of trauma issues.

So the Category I center, the national center that I mentioned is at UCLA and Duke, and also had, and Barbara noticed this, has a contract with the Federation of Families for Children's Mental Health. It was a commitment made early on that we wanted to make sure that families were involved at the outset, at all levels of what the trauma center is doing.

But this center provides leadership, develops and maintains the network structure, provides technical assistance to the grantees, coordinates the education and training. It is really the hub that brings these pieces together.

Then there are the two other categories of grants. These Category II grants are the treatment and service adaptation centers.

Are these slides in your packet? I'm not going to go through all of these.

It lists out a variety of kinds of activities that these centers do. They are primarily university-based, and they are the ones, and I'm not going to go through all of these. They are the ones that develop, implement, and disseminate the effective interventions in these particular areas of trauma expertise.

They also play a role in training around these

approaches, develop the products, and they also see how trauma interventions can be adapted to different kinds of communities. Does something work in rural communities as well as in urban communities? With different populations of children? Maybe those in foster care, or those that are in other kinds of settings.

So it's how we learn from what works, and then see how it can be adapted to other settings and other populations. If you skip over to the Category III slides, the Category III grantees, the community treatment and services centers, these are the centers that are actually providing services in communities.

So that we can take these interventions that we're learning about and support them, taking communities and different childhood systems and make sure that these are sustained in the communities. The Category III grantees also do some evaluation of the interventions that are going on in their communities because they are in different communities across the country. So again, we represent different populations.

So today what we're going to do is focus on examples of two of these Category III treatment centers that have different populations and different areas of focus.

Our two speakers today, and we're very

fortunate to have them here, are Dr. Elizabeth Thompson, who is the Director of Clinical Services with the Kennedy Krieger Family Center, which is in Baltimore and does a lot of work with children exposed to community violence, sexual abuse, child neglect, so she'll be talking about some of the interventions and approaches there.

Then we have Bob Hartman, who is the Executive Vice President and COO of the DePelchin Children's Center, which is in Houston, Texas. That is a large, multiservice agency that provides services to children exposed to a wide array of trauma. But also the DePelchin Center was key in assisting the evacuees that came to Houston and to Texas and did a lot of training of the shelter workers around what to look for in terms of the children that were impacted by Katrina and by Rita.

So these are people who are very much on the front lines and we're very happy to have them with us today. After they present, we'll have some time for discussion.

DR. THOMPSON: Thank you. I organized my presentation to sort of talk about life at Kennedy Krieger Family Center before SAMHSA and life at the center after SAMHSA.

Kennedy Krieger Institute is a facility in Baltimore that has an international reputation for

providing services and improving the lives of children with developmental disabilities, pediatric developmental disabilities. The Family Center is one of 40 outpatient centers that come under the Kennedy Krieger Institute umbrella. We were established in 1985, and the original mission of the Family Center was to meet the unmet mental health assessment and treatment needs to children who were in the foster care system that did not have services being provided to them.

As we began to work with the children in foster care, what we quickly discovered was that not only were these children in foster care, but these children had also experienced a great deal of sexual abuse, physical abuse, and maltreatment, domestic violence, and community violence.

So as the Family Center began to develop programs, we sort of broadened our scope beyond the original mission of working with children in foster care, and ended up developing programs and responding to children and families that had been impacted by violence.

When we started about 20 years ago, 100 percent of our children that we served were in foster care. Today that amount is about 50 percent. So it is not as large as the original population when we originally started. But clearly foster care still represents a large segment of who

we provide services to.

Prior to our involvement in SAMHSA, there were a lot of things that we were very proud of. We had established a real expertise in the community of working with chronically traumatized children. These are children who not only experienced a single trauma, but kids that experienced lots of traumas over a long period of time. That was the area that we had a great deal of expertise in, and a lot of clinical knowledge. We had developed our programs in an effort to be responsive to this population.

Another thing that we were doing very well I think before we received the SAMHSA grant and became a part of the network is that we developed a lot of specialty clinics. So, for instance, we have a clinic that works primarily with children that are sexually abusing other children as a function of their own unresolved sexual abuse issues.

We have a family clinic that works very well with children who are experiencing children and families who are involved in multi generational trauma. So we have these clinics, so we really developed in ways that allowed us to treat specific population of traumatized kids in a very focused and organized way.

Both SAMHSA and the network placed a lot of emphasis on cultural awareness and service delivery, and

this is another thing that I think we were doing well before we received SAMHSA. From the moment I interview a potential staff person, we talk about the importance of cultural awareness in service delivery, staff are expected, it comes up in supervision. It is actually part of the written performance evaluation. So it is not something that we just pay lip service to, it's infused in every aspect of our agencies. In fact, it's one of our guiding principles.

We also have very established partnerships with child servicing systems, child serving systems in Baltimore City. The Baltimore Department of Social Services, we have a longstanding relationship with Baltimore Mental Health Systems, which is the agency that provide all of the public mental health services to children involved in the city. We also have a long-term relationship with Baltimore Child Abuse Center, which is a single point of contact for all children that are sexually abused when the abuse is reported, of course. It's a single point of contact for all of those kids.

The Family Center serves approximately 1,000 children a year on an average of 17,000 visits. In addition to providing services to children in our clinic, we also have therapists who provide services in four schools that are located in very high crime areas in

certain Baltimore City neighborhoods. We have therapists who go to the homes for clients who can't come in.

The next couple of slides will give you an idea of what our population looks like at the Family Center. As you can see, 91 percent of the children have experienced at least one traumatic event. I think you can see that this is sort of a list of the types of trauma that we have provided treatment for at the Family Center, and some of the frequencies.

This is just a list of the ones with the highest frequency. We actually document about 45 different types of trauma. This just gives you an idea of those with the highest frequency. The average kid that we provide services to has experienced three traumas. Not necessarily on this list, because this is not an all inclusive list, but the average kid has experienced three traumas.

We actually have children who have experienced 10 and 11 different types of traumas. So that begins to give you a picture of the kind of children and families that we're working with.

This is a list of parental issues. This is a percent, this slide is really birth parent issues. The thing to keep in mind is that we have children in birth families, and we still have a significant portion of our children who are in foster families. But you can begin to

see some of the things that are critical to look at and understand in terms of working with children that have been traumatized.

Not only are the children traumatized, they come from primary families that have a set of issues that pose additional risk factors.

To kind of give you the story of our involvement with SAMHSA and the network, to take you back a few years before we were funded in '03, probably around November or December of 2001, we began at the Family Center to make a very purposeful and strategic effort to improve our program in certain areas.

One of those is we decided to improve upon our outcomes evaluation system. Another thing we decided to do was to begin using treatments that dealt with the neurobiological impact of trauma. A third thing that we decided to do was to encourage our staff to integrate research into clinical practice in a more deliberate way.

Probably in early 2002, one of the things I did in terms of trying to change the culture was it was somebody on my staff's responsibility to review the trauma literature that was coming out in academic databases. At some point she discovered that there was this trauma network. Of course we made some phone calls and somebody said it is too late, you can't get it in it, it is already

set.

I remember how disappointed we were, because even at that time, we felt like we would have been a really good match for the network because of the things that we were doing, and because of the things that the network was doing.

At that time, I didn't know that this was sort of rolling funding, so I had no idea then that we would get another opportunity. In 2003 when the RFA came out, this is a true story, within five minutes, three people on my staff emailed me and said, Elizabeth, look, there is another chance, we have to go for this.

Interestingly enough, I hope this is okay to say, I'll say it. It is the only time that I have ever been involved in a grant writing process that I was actually pretty confident the whole time that we were going to get the grant. That's how strongly I felt about the match that our program was to SAMHSA.

Of course we were funded in 2003. Because of the support from SAMHSA both in terms of the funding, but also in terms of the regular contact and the support and the network collaborative structure, we've been able to improve the standards of care and access to services in Baltimore City.

I want to say a bit more about the network

collaborative structure. I believe it is the network collaborative structure, that's one of the things that makes the network work so well. It's the collaboration.

It's funny. I told my daughter I was going to be nervous this morning. She asked me, don't forget to have water with you, because when you get nervous, you have a dry mouth. Interesting, even though she's a 13-year-old in the 8th grade. You can bet the conversation I'm going to be having with her when I go home.

(Laughter.)

DR. THOMPSON: So it's not just 45 different agencies doing their own thing coming together once a year. There really is strong collaboration in an ongoing way. We share resources, we submit data to a common data pool. Phone conversations, email conversations, meetings, so the collaboration I think is really key. You get to form relationships and sit at the table with other experts in the field of childhood trauma. That's a pretty unique setup.

Raising the standard of care. While this slide, I want to divert just to give you one example. We have really seen improvement since we've been in the network in terms of individual therapy, in terms of my own program at the Family Center, and also the impact that we've been able to have on Baltimore City.

Just to give you an example, one of the members of my staff who is fluent in sign language joined one of the network's working groups. It is called the Adaptive Treatment Standards Working Group for children with disabilities.

The purpose of the working group is to look at how treatment can be adapted for children who have special needs. So she joined this workgroup, and she was fluent in sign language. She came to me probably within a month of joining and said Elizabeth, can we start a clinic where we provide trauma focused services for children and families who are deaf and/or hard of hearing?

So you attempt to go through the fiscal part of it and how you're going to do it, and the operations piece. Of course I said yes. We have had a tremendous response. There were people providing mental health services for children and families who were deaf and hard of hearing, but of course nobody was providing trauma focus. So that is a perfect example of how based on a collaboration from the network, we were able to improve services in Baltimore City.

So impact on KKFC culture, one of the things that we thought we were doing a pretty good job was around incorporating families in treatment at the Family Center. Of course we found out, as everybody I'm sure knows, both

SAMHSA and the network placed a really high priority on engaging families.

This was something we thought we were doing a pretty good job in. But we tended to view engagement primarily in terms of engaging families in the treatment process. Of course that's just the first step.

One of my staff again had the opportunity to join a network working group, it's the Consumer Engagement Working Group, and I think to this point the culmination of this group's effort was a consumer engagement conference that occurred in October, I think. That's where the Federation of Families was critical in helping the network develop that.

One of the things that two members of my staff who attended that were most excited about is that there were 50 percent consumers there, and 50 percent professionals. Of course that's unusual, because a lot of times you go to these conferences and people pay lip service to having consumer involvement, but there is a room full of professionals and then two family members sitting to the side that they bring on.

This was a conference where over half of the people there were consumers. I think one of the neatest things that one person on my staff said, you didn't know who was who. That's pretty powerful.

What we began to realize is that engaging families in treatment is just one piece of it. It's really more about engaging families as real partners in program development and service delivery.

We made a decision a couple of months ago to make this one of our strategic planning goals to ensure that it stayed on the front burner and we didn't lose track of it. A good example is that we recently decided to start implementing biofeedback and some similar kinds of techniques. Before developing the program, we decided to engage a group of care givers to help us decide how we should develop the program.

That really is a first for our agency. It is just the first step. We have a long way to go, but I think it was very important, and I'm certain had it not been for our involvement in the network and hearing SAMHSA and hearing the network talk about it and making it a priority, I don't think we would have done so in our own organization.

Staff improvement. Adoption and adaptation of best practices. Of course, and this kind of gets us into the conversation of evidence-based treatment. Evidence-based treatment is not the only avenue to quality mental health, but it clearly is an important one.

One of the things that we paid a lot of

attention to are evidence-based practices. Now, one of the things I think it's important to know about the network is that they have a learning model or an approach to training that goes way beyond just this single shot training where you go in and you train somebody on a new technique, and you leave and you don't know if they learned the technique, if they've implemented it, if it had any impact.

The way the network views training is that it is an ongoing process. There really is a commitment to knowing that not only have you learned what you have been trained on, but it has been implemented and implemented effectively.

One of the ways we have seen this in the network is our work around learning trauma-focused cognitive-behavioral therapy. Trauma-focused cognitive-behavioral therapy is one of the best practices. There is a tremendous amount of evidence that says that trauma-focused cognitive-behavioral therapy is very effective with children and families that have been traumatized.

So we started with a single training in Allegheny, as a matter of fact, we went to Allegheny Hospital in Pittsburgh, which is a Level II site where trauma-focused CBT was developed.

Subsequent to that initial training in Pennsylvania, the network established regional trainings

around the country. My staff attended the one that was in New Jersey with a Level II site. After that second training, there were these monthly consultation calls, and then an advanced training.

So you get the idea that it's not, again, not a one-time thing, but it's training and follow-up, and a real commitment to knowing that clinicians have really learned the model in a way that it can be implemented effectively.

The phase that we're in now is the National Breakthrough Series Collaborative. The important thing about the Breakthrough Series Collaborative is that it goes beyond the individual clinician learning trauma-focused CBT, but it is helping us understand how does trauma-focused CBT get implemented at the organizational level. So it's about identifying barriers and solutions to those barriers that enable us to implement it at the organizational level.

How does the community get involved? How do judges and other people who refer children to your agency kind of understand trauma-focused CBT? What are the fiscal issues that impact? What are the therapist's attitudes that impact the ability to implement this?

We like to think of ourselves as change agents in the systems that we work with. One of the things we were able to do with our SAMHSA dollars is that we

established a training budget. We have been in the network now two years, we have conducted about 24, 25 trainings. We have actually trained about 800 people, parents, police officers, pediatric residents, school teachers, DSS workers, a host of people on how to work more effectively with traumatized children and families in their service sectors.

So how does a school teacher do her job more effectively if she is more trauma informed? How does a pediatrician do his more effectively, and so forth and so on. I didn't watch my time.

MS. GOLDMAN: Three or four minutes.

DR. THOMPSON: Three or four more minutes. Okay. Let's see what I'm going to skip.

MS. SULLIVAN: That never works for anyone. Just go ahead.

DR. THOMPSON: Thank you. It is because I actually timed this.

MS. SULLIVAN: Just go ahead.

DR. THOMPSON: Thank you.

The community advisory board is something I'm really proud of. Again, the community advisory board is post SAMHSA, it has a team who received treatment, have completed treatment, two teams in fact and a couple of care givers on this board.

They, as well as the agency that I mentioned earlier, they are on the board also. What they have told us is that their involvement with our center, they are more trauma informed, we have helped them develop training in their own centers.

One of the messages we have been able to get across is that when you work with traumatized children and families, it is not enough just to have a general mental health background about children, you need to have a very focused and specific background as it relates to trauma. You also need to be aware of best practices.

It is a focused approach, and trauma is right there on the table. We used to think it would take a year to develop a relationship, and it has gone on and on and on. Now it's clear that it is much more focused and much more direct. You need training to understand that.

The product development, the network really is into developing products. A couple of people on my staff have been involved in developing a product for child welfare professionals that teaches them how to be more effective in their job. This is something, there were about 12 or 13 sites involved with this child welfare product.

To give you an idea, 13 people involved in the development of a product, if you think of that many

agencies and people being involved, and doing a lot of the work in conference calls, too, you can kind of begin to get a sense of how things develop.

The reason this accelerated is because the network made its decision that this was a product that they wanted to push along and get out very quickly. The Public Policy Roundtable provided us an opportunity in Baltimore, what the Public Policy Roundtable was is they were representatives of 15 states, the network project director, as well as the person responsible for Department of Social Services, and the person responsible for children's mental health in the state.

Because the roundtable was actually held in Baltimore, we had an opportunity to bring together the Director of the Department of Social Services, who actually has since resigned unrelated to this Public Policy Roundtable, but we had an opportunity to bring him together for a first meeting with the person who is the Director of Children's Mental Health in Baltimore.

That's an opportunity that we would not have had. I don't think we would have gotten presented were it not for the Public Policy Roundtable.

A public awareness campaign, improving access to services. There are at least a couple of ways to think about improving access to services. One is you can look at

the concrete things like transportation, cost, location, and some of those kinds of things. Another way to think about it is in terms of people's attitudes about service and mental health, and whether or not they seek them out based on their attitude and stigma.

So our community advisory board decided to attack public awareness from this perspective. I'm sorry, to attack access from the perspective of public awareness. What were people's ideas about trauma and how did those ideas either lead them to or away from seeking treatment.

So we actually hired a professional facilitator and conducted full focus groups in four Baltimore City schools with care givers and a Head Start program. We found out, not surprisingly, that these were the four neighborhoods that a tremendous amount of community violence where kids don't even go outside during recess time because of gunfire in the neighborhood.

So it is hard for me to imagine going to school and not being able to go outside for recess because of gunfire going on. So these were the neighborhoods that we conducted the focus groups. Not surprisingly, when people asked what is trauma, they thought death was trauma. The teams, as well as the adults thought this.

The teams were pretty clear that we needed to develop a teen campaign and an adult campaign. They felt

like a message targeted towards adults would not be the same message that you needed to use towards teens. But the teens and the adults felt like death was what trauma was.

They also believed that this was a normal part of growing up. A significant amount of the care givers believed that living in these kind of neighborhoods sort of prepared children in a positive way for life later on. So there was a real normalization of the trauma that they had experienced.

I'd like to end with just a brief word about some of the work that several of my staff did. We were asked to go to Anne Arundel County to work with a group of teenagers that had been relocated because they had experienced Hurricane Katrina. So we were asked to come and do a one-time group to work with children and teens that had been traumatized.

So the teens were given the choice of either choosing an art project or a verbal project, something written. They chose the written project. What the assignment was, they were given a choice of eight words, and they were told they had to choose five of the words, and then they had to create a poem. A poem with five lines, five stanzas. The entire poem had to have five stanzas, and each stanza had to have five lines. They had to use each word on a rotating basis within each stanza.

It included a word or a line that the entire group had to agree on. So the words they chose, because of the work that's being done in the network, healing and recovery occurring in a better way now than it was. But nevertheless, trauma changes you forever.

The second lesson is that we can never lose sight as mental health professionals, and I'm an administrator now, but I started out as a mental health professional, and as a mental health professional we can never lose sight of the hope and resiliency that families glean when they come to us for treatment.

"Strength is a powerful thing. Miss our friends, hope to return, life, glad to have it. Change is hard. Miss our home room, hope to find missing people, life for the future, change for the better, strength to carry on. Hope for life, life is different, changing friends, schools, culture, strength from my momma, miss the flood, life should be withheld with love, change is versatile with good or bad.

"Strength from people that believe what you do. Miss Mardi gras, hope that people's pride will stay alive. Change is a blessing in disguise, strength from living in New Orleans. Miss school, hope from God, life should be cherished. Love with open arms, love is an obstacle and confusion."

The group decided at the end, my thought as being teenagers, that after agreeing on the five words, there were a couple that wanted to add the last stanza. So they decided to end with "Again, love with open arms, love is an obstacle."

Thank you.

(Applause.)

MS. GOLDMAN: Thank you, Elizabeth. I think your presentation really gave a wonderful picture of not only what you do with teens, but how you are touching people's lives, how you really have connected to this whole network, and how it really does support our work. That's what we're hoping will happen.

Bob, do you want to take it?

MR. HARTMAN: Thank you. Wonderful, Elizabeth.

DePelchin Children's Center is one through 12-year-old agency in Houston. Houston is the fourth largest city in America, so we have also grown to be a large organization with an array of services. We have services that -- Kennedy Krieger actually span from early intervention services to mental health counseling because of the merger early on with the Child Guidance Center to services for homeless moms because we're affiliated with the Florence Crittenton Center in Houston to home-based and community-based therapy services to therapeutic foster

care, residential, intensive residential treatment services, and additionally an option for children who are in foster care to post-adoption support services for those families.

I liked Dr. Thompson's statement about prior to this grant and after this grant. For the last 20 years, we have been very active in writing grants for state and federal initiatives. We are 80 percent successful in landing grants. We have a large research and grant management department that tracks our grant activity.

This grant was so different. This became a catalyst for transformative change for us.

Just on a slide here that talks about our goals, we actually mirror SAMHSA's goals and what they're wanting to achieve for the trauma initiative. Increasing accessibility. Developing for us a community network of professionals to do that access to care.

We wanted to become a learning organization. We knew that though we serve about 27,000 children and families each year, about 5,000 of these kids have experienced multiple and complex traumatic incidents. We see that this cuts across all of our services as well.

We wanted to of course improve outcomes for kids and translate research that we are seeing in the network into our own practice.

I will talk briefly about some of the accomplishments we've been able to achieve over the last two years with this grant. It has only been two years, which is amazing. We hit the ground running when we were awarded this opportunity to serve children in this different way.

Rather than reading through all of these various accomplishments, let me highlight a few. Media placements and media response. I'll be talking more about our agency's response to the Katrina and Rita hurricanes in a minute. But one of the media placements, if we can pull it up in a minute, is --

MS. GOLDMAN: This is a Word document that they're switching to a DVD.

MR. HARTMAN: Then we'll wait for that media placement. Hopefully that will come up for us. That's a PSA that we developed for the Katrina evacuees.

One of the first things we did was we established an internal core trauma team. We saw this group as being the ambassadors internally for change, to change our culture, to become a learning organization.

We had 15 people from different departments within our organization come together monthly to plan, to prepare, to learn, and to disseminate information to each other throughout our organization.

We also established a community trauma network so that we could be a part of training, and to disseminate materials that SAMHSA and the National Child Trauma Stress Network has been sending to us. Over 200 organizations have become involved in this. We have been able to provide 78 training sessions for over 2,500 people just this last year.

This is all new to us. We hadn't been doing this kind of thing in the past. We have actually put network counselors on our website so that there is increased access for people if we are busy, if the location doesn't fit them, then those people around the community are available as well.

In terms of our NCTSI collaboration, we were nervous about this initially because everyone had said jump in and be a part of the national network. We had so many different services that seemed to relate to all the task forces. We cautiously put our foot into about five, and then in the last eight months or so, have expanded to foster care workgroup, Data Corps, Public Policy Corps, school intervention, system integration, residential workgroup, training, and Data Corps.

It really has been impressive, the information that we have been able to share, the information we have been able to glean from these opportunities to connect with

our network.

We've developed papers around financing for a child welfare service, monitoring psychotropic drugs in the child welfare system, workforce issues in implementing trauma care, as well as how to establish a community collaboration around trauma services.

The training has been very supportive, as Dr. Thompson mentioned earlier. We have been involved in a trauma-focused cognitive-behavioral therapy parent/child interactive therapy. That, by the way, for us was interrupted because of the Katrina hurricane. We couldn't participate in the second round of that training, but we are planning to do that later.

The sanctuary model for residential care as well. I'll share that experience with you, that the intensive residential treatment center entered a partnership as a result of this trauma network with the Department of Family and Protective Services to determine if we could better serve kids in our residential care who are specialized in intense needs, and then can those kids move on to therapeutic foster care environments and be sustained there.

We changed the culture as a result of this sanctuary model implemented in our center. Let me just share with you some of the statistics regarding that.

Twenty-four percent of the kids that have come to us have higher level needs. So we see that the department is seeing us as a resource for some of the hardest kids, kids who have been to other residential care facilities prior to coming to DePelchin.

Sixty percent of those kids discharged from the residential care have moved to a less restrictive environment. We have been able to see 87 percent of those kids stay in their therapeutic foster home or move onto their birth families, or to an adoptive placement.

We have lowered the length of stay 50 percent compared to the state average. We are seeing now an 89 percent reduction in restraints and seclusions. We have a residential center that houses about 40 kids. We stay full with about 38 as an average.

Prior to starting this initiative, we were restraining kids and secluding kids for disruptive behavior about 51 times per month. Now we are about five per month, way below the national average of around 20. I think you have to look at 1,000 days, the number of kids in care over that length of time. It is just truly remarkable.

Texas calls a hand holding onto an elbow escorting out of a room, calling that a restraint. We have actually been able to shift much of the restraint activity to an escort to change direction for a child. We credit

this to our work within the trauma network.

There is a portion here that says translated research into practice. One of the successes is advocating for a major change in the child welfare system in the State of Texas. Senate Bill 6 was passed this last year. We actually hired a Director of Public Policy Government Relations, and as a team, we testified in Austin for compassionate care for children, for systems to be more integrated for their care, for case management to be more continuous, and for the trauma that every child in foster care has experienced to be dealt with adequately, and the legislature certainly accepted that.

Let me move then to a more dedicated effort when Katrina at the end of August, early September, began to impact Houston. For us, we are so fortunate that we had been a part of this network for almost two years at that point. We felt ready to be a part of the solution around this major issue.

Just to let you know, we receive calls often from our SAMHSA staff liaison from the National Child Trauma Stress Network and they say how are you doing? Are you holding up? How is it going? I can share that it has been chaotic, overwhelming, confusing, exhilarating, challenging, and heartwarming and heart wrenching.

We made a priority decision to put aside many

of our priority activities to focus on Katrina evacuees. That has been a very important step for us in responding to the care needs. However, you can't put aside 400 kids in foster care, now almost 50 kids in the residential center. We have another residential center as well. Those needs and those services go on.

Let me just share with you in terms of direct service response, we are immediately responsive to the kids who were at the Astrodome, there were about 25,000 families, people at the Astrodome within about an 8-day period. People streamed in on buses as you saw on the national news. The George R. Brown Convention Center had 5,000 people.

We have a relationship with Baylor School of Medicine, School of Psychiatry, and also the psychology department where psychologists are interns at DePelchin. These doctoral candidates and post-doctoral candidates, we deployed into the large centers for counseling round the clock shifts, as well as our psychiatrists. We have six different psychiatrists that work with our populations.

We have received 20 referrals for foster care placements. We have worked with the Covenant House from New Orleans who have come to Houston working with 74 of those kids and about 25 staff members from Covenant House for counseling and support. We have assisted the schools

with the two schools, new schools, that Houston independent school district set up for these kids who have been evacuated, as well as 50 other schools around the Houston area with counseling, consultation, and training.

Let me tell you a real touching story that occurred with a homeless teen who came from the Covenant House connection in New Orleans. She was about ready to deliver right before Katrina. She got on the bus, came to Covenant House. We had actually a set of apartments on our campus for homeless moms. We have a transitional living program to help young families.

We were able to bring her into our program. When she then gave birth, we helped. We were the breathing coach in the hospital. One of our managers was at a national Florence Crittenton Center conference connected with a Crittenton Center in Montana that wanted to be a part of this solution. They offered to start a new life for this young woman, Adrian, and her daughter, Dominique. We really thought that she would call her daughter Katrina Rita, but she didn't do that.

This Crittenton Center has taken this young family in, and is now caring for her needs. That's really exciting to us.

Well, there are many more incidents of direct service. The State of Texas allowed our home and

community-based therapy program to incorporate the funding, access, and the intake process for that service, and we have been able to serve 120 families just through that same process that we have been serving.

Just recently we have been able to work with the Houston independent school district to sign a major contract that will allow us to provide individual and group therapy sessions with kids, group experiences for families, and this is where the engagement of families is going to be very critical. We'll set up family council around deciding what kind of support people need, and consultation and training within schools as well.

We were able to coordinate and communicate with the national network, responding to their calls. We distributed the psychological first aid packet that was just out at that time, as well as a trauma screening tool. Fortuitously when Katrina hit, we had been planning a regional training conference on child traumatic stress.

The state director, or assistant director of behavioral health, Dr. David Wanser, I believe called Charles Curie, who then connected with staff members and put everybody in touch with the NCTSI site at Houston to help train, as Ms. Goldman mentioned, the center staff that were dealing with sexual abuse issues in their centers, that were seeing child abuse and neglect and didn't quite

know how to deal with these issues.

So we were able to add workshops into our conference so that those people can participate. That was just marvelous.

In terms of public awareness and response, we received calls from "20/20," "Nightline," "Paula Zahn Now," the AP, all the local TV and radio stations, Houston Chronicle, New Orleans Times. It truly was an overwhelming time for us. We have a marketing department that worked with the national center here that was able to triage these and provide points of discussion that helped us deal with this.

I don't know if it's possible to see the PSA that we developed, that we could show.

(PSA shown.)

MR. HARTMAN: We have an access department with six telephone operators. Our calls have gone to 1,600 calls per month since Hurricane Katrina as a result of these ads and other kinds of activities we've done. We are now receiving about 96,000 calls per year.

During our response to Katrina, Rita was offshore, and Rita was heading towards Houston. We had then to prepare for our own evacuation. We evacuated 200 kids from foster homes with the foster families. We were tracking where they went to make sure that they were safe,

and provide consistent care, as well as our residential treatment centers, we wanted stability there.

But our training and trauma care had us thinking we're going to now require foster parents to sign an emergency plan as part of their preparation for foster parenting in case something like this happens so that we all know what process to go through.

In terms for us for the future, trauma care, especially after a hurricane, there is an immediate response for psychological first aid, and then there is a longer, slower kind of trauma build up that kids begin to experience and show later on.

Now that families have calmed down enough, we are seeing a lot more disturbances in schools, whereas initially everybody was in shock. They weren't displaying the trauma that they experienced. We know that the access points for us will be the schools, public health departments, pediatrician's offices, and daycare centers. That would be kind of a front line noticing what kids are needing.

Our board has recently gone through a strategic planning process and realized that this grant has transformed the way we provide service. It is a cohesive type of initiative that if you read Jim Collins' book, "Good to Great," it's a hedgehog concept for us.

Therapeutic care for kids, especially in the child welfare system.

I think I will end there. You have the material in front of you. But I just want to express my appreciation for the work that SAMHSA has done through this and the National Trauma Center.

I think we're open for questions.

(Applause.)

MS. GOLDMAN: Yes, we're open to questions to both of our speakers here. As I mentioned before, we have staff here from the branch, Dr. Gordon and Dr. Casale, who can answer your questions as well, or myself. So it's open.

Toian reminded me that you all have to be out of here by noon sharp. There also needs to be an opportunity for public comment, so we will have to watch the time for those events.

Barbara?

MS. HUFF: First of all, thank you very much for your presentations.

I wanted to just make a comment to you, Dr. Thompson. I wanted to just say in sympathy (inaudible) family guidance in the child welfare system, and it's really good It might be a nice companion to what you've developed. It was developed over a year time and it will

be on Georgetown's website because they were instrumental in doing a lot of the work on it. Families also were part of the development of that, which I know you all appreciate. So that's just an FYI.

Then Bob, I wanted to ask you, in the reduction of seclusion and restraints, you gave a lot of credit to the trauma center. Is that in training? Or tell me about that. I want to know what it would take them to get the other 5 percent of seclusion restraint gone, if you think that's possible.

I think we have a lot to learn from people who are actually trying to reduce seclusion restraint, because this has not had a successful entry. So could you speak to, you said you gave credit there, but you didn't say how that happened.

MR. HARTMAN: It was a very focused effort by our administration to review every single restraint, to track it by time of day, by child, by staff member, by length of time of restraint, the type of restraint.

We had a weekly meeting established around this. Lots of training. A different way to talk to kids. A residential center tends to want to control kids so that they don't get out of hand too quickly, because it can be kind of an explosive environment with kids with very specialized and intense mental health needs.

So we began talking to kids differently, and preventing and anticipating the need for restraint to help staff recognize their own emotions prior to reacting to an issue, and involving teams of staff so that if somebody is hooked, then you turn to the other staff member and say will you please work with us?

We debrief and we plan with each child and with each staff whenever there is a restraint. We told staff early, we will gladly give up a chest of drawers, but we don't want to retraumatize a child in restraint. So we've had more property damage, and staff has to allow that to occur.

No, we wouldn't allow that in our own family, but these kids are not normally in families in this kind of way. So it has been a process now for about a year and a half. I don't believe it is possible to fully reduce all restraints, because you want to protect kids. Some of these are in response to a child harming himself or others.

So typically now we see it focus on a few kids who have the most restraints, and we begin looking at their case plan, that will allow us to be a step down for them, and for them to be a respite for some of our kids as well.

MS. HUFF: I congratulate you.

MR. HARTMAN: In a nutshell, that is kind of how we address that.

MS. HUFF: (Inaudible.)

MR. HARTMAN: Well, and we just realized these are not bad kids. They have had bad things happen to them, and they are reacting in some behavioral way to something that happened years ago. We realize that this trauma squirts out in unusual ways at different times in a kid's life. That's what we're seeing as staff. So they've learned more.

So the therapy, we have therapists there. Therapy has really shifted from the therapist to the youth care workers who develop the relationships with the children, we recognize that.

MS. HUFF: Thank you.

MS. GOLDMAN: I think that centers and providers that have made this kind of conversion are the best way to train others about how to do this. Seclusion and restraint is one of the major kinds of traumas that kids would be experiencing, so maybe there is a way to do some of this kind of training through the national network.

PARTICIPANT: Can I ask a question or save it for public comment?

MS. VAUGHN: No, I'm sorry. This is just for the council.

DR. GARY: I want to commend both of you. I found the presentations to be enlightening, but also

informative. I wanted to also comment about the therapeutic approach that you are using, and the sense of commitment that I sense from both of you, the sincerity of the work that you do.

I just wanted to follow up and make a comment about the networks, because I think if you look at the networks, you could coin the networks and call them invisible universities, if you will, because the networks indeed embrace a certain perspective and provide the evidence, but also provide the strategies and tools, the behaviors that must change in a staff in order for it to work.

In a sense, you have created your own invisible universities. The next question would be then how is it that you can continue to impact other facilities that may not be in the network that are located all over the United States, and invite them to become a part of the network so that you can educate them with the knowledge that this invisible university now has.

That's the first observation. The second observation is I find the area of seclusion and restraint a very dynamic one, because it is a judgment call. It is a judgment call that's made by staff. It is based on staff's previous life experiences also. You did not address that point.

So I wanted to ask if you would address how you assist the staff in handling their own trauma, and their own anxieties, their own fears and frustrations about aggression. Aggression is conceptualized quite differently when you look at ethnic minority males. You look at Hispanic males and black males and aggression, you're into a very different realm. How do you address those issues with your staff?

MR. HARTMAN: Wonderful reflections. A couple of things regarding training. We have been, and I believe Dr. Thompson as well, have been active in our own national networks of service. Child Welfare League of America, the National Alliance for Children and Families, and on the state level as well, the Texas Alliance, which provided multiple training sessions around these kinds of issues that we've talked about today. Those will just increase.

We met last week with the Department of Family and Protective Service senior staff, as they are looking at the privatization initiative around child welfare, and offered the opportunity to train around seclusion and restraint and trauma-related care in integrating systems of care that make sense for kids so they're not retraumatized.

Regarding staff, that's a very good point. We have changed the way we're interviewing staff at the beginning of the hiring process, and talking very much

specifically about those experiences and how they respond to people getting angry and people using language that might hook a certain reaction.

Then it is a subject of staff meetings, of the debriefing sessions after each restraint so that we help and nurture staff so that they have begun to change. We have a core staff of probably 15 people that have been there an average of between 10 and 12 years. So they have made a dramatic improvement. These aren't new people that we're hiring into it.

So it is working with those ways they used to work, and changing that culture.

DR. THOMPSON: And I'd just like to add a couple of comments to that. Your remarks sort of triggered two things in me.

The first is the comment about aggression and staff history and how that impacts their ability to deal with it. Two things that we do at our agency. We have a secondary trauma support group, because one of the things we are very aware of is that when you work with kids that have been traumatized -- your own history then because of the impact of work, you have to be careful, thoughtful, and promote self-care, because they are also impacted by the trauma.

So we have an ongoing support group with

therapists who talk about that that actually doesn't have any administrators or supervisors in it, because one of the staff, you know, felt like they would be freer to kind of talk about those kinds of issues when there wasn't an administration person there.

The second thing was the issue of cultural awareness. I think when you talk about African American males and Hispanic males, you are absolutely correct that you start treading different territories. One of the things we're clear about is you have to be aware of this from a cultural competence perspective. So we talk to staff about that.

We do a lot of adolescent male groups, and I have had staff who have been fearful because the males are taller than they are, and are bigger, and interact with each other in a way that 85 percent of our staff is African American, and only about 20 percent of my staff is African American.

So for us, it's something that we address on an ongoing basis.

MS. GOLDMAN: I'd just add one, Dr. Michael Wong, who is with the National Center when we were doing the visits to the schools across the Gulf, she talked a lot about compassion fatigue and how much work you have to do with all of the care givers and providers, whether they are

teachers or whether they're the workers in your centers, and how much support they need.

She also made the analogy of the airplane when they say put your life mask on first before you help your child, that the same thing is true in terms of any of these centers where we are providing services, that a tremendous amount of support has to go to the staff, because this is very hard work, and they need that kind of help.

MS. DIETER: I don't really have a question. I just wanted to thank you both for what you're doing. This morning for me, your reports were particularly impressive, because they embodied a sort of evolution of your centers.

I don't think that's always the case. People you hear from talking about a project they're doing, your sincerity is wonderful, and also sort of a very thoughtful openness to change and development of improving things all the time. It was very impressive. Thank you.

MS. GOLDMAN: Any other questions?

(No response.)

MS. GOLDMAN: Well, I just want to personally thank both of you, Bob and Elizabeth, for excellent presentations, and also for the staff that I have the honor of working with at SAMHSA who head up this program. I think it has made some extraordinary advances, as I said before, in terms of what we've learned about trauma and

treatment.

Also for your request to hear about programs, because it is so easy as we give out grants and project officers for all of these different efforts that are going on in communities, not to focus on what it is that these grants are supporting on a day to day basis that helps children and families and people struggling with addiction and other mental illness. That's really what SAMHSA is all about. So thank you.

MS. KADE: Thank you very much.

(Applause.)

MS. HUFF: I'd like to say thank you for having such a focus on kids this morning, and also for hearing us when we said we wanted to hear from more people in the communities where real services were taking place. Thank you for hearing that.

MS. KADE: Good. Thank you.

Before we go into public comment and some closing remarks, I wanted to introduce Mr. Ron Seger, the founder of Race Against Drugs.

MR. SEGER: Thank you. I know that you all are going to break very shortly. I wanted to introduce you to a program when you talk about kids. Our kids focus on Motorcraft sports. Our focus is we all look for something that is going to attract the attention of young people and

get them to listen to our message. It's the color, speed, and excitement of that sport.

We have a program called Race Against Drugs. Four hundred and fifty thousand of these coloring books, they are activity books, were just distributed to Texas, Louisiana, and Mississippi by SAMHSA.

When you break in front of the vestibule that you came in, there are some posters. Please take as many as you wish. They're all exciting. We use subliminal messages. We want children to take them home and put them on the walls. They'll get the message.

When they are watching NASCAR every Sunday, a lot of the drivers that drive for NASCAR are some of our spokespeople, and we found a long time ago that as adults, as law enforcement, when we make a presentation, the kids are fidgety. They're doing other things.

When I get a well-known race car driver standing up there, and they recognize him because they just saw them on TV, they listen.

When you walk out of the building, there is a Motorcraft car sitting out front. It is one of the cars that we use. We have 24 different sanctioning organizations that work with us.

I only had a short period of time. Thank you very much.

MS. SULLIVAN: Wait, wait. A couple of drivers, a couple of the motor organizations, and you said "we as law enforcement." Obviously, you are with law enforcement.

MR. SEGER: No, ma'am, I'm not.

MS. SULLIVAN: Okay. A couple of the drivers and NASCAR and who else?

MR. SEGER: We work with 24 different sanctioning organizations. Most of their drivers that work with us (inaudible).

MS. SULLIVAN: Indy cars?

MR. SEGER: Indy cars, NHRA, Grand Prix, everybody that is involved with motor sports.

MS. SULLIVAN: And what drivers?

MR. SEGER: People like Richard Petty, Daryl Walker, Bobby Hill, Jr., (inaudible). Those are just NASCAR drivers. The entire Andretti family.

MS. VAUGHN: Would you tell where your car is located?

MR. SEGER: The car is located right in the front of the building as you walk in.

MS. SULLIVAN: And Ms. Patrick, is she?

MR. SEGER: Oh, Dana Patrick?

MS. SULLIVAN: Yes.

MR. SEGER: We've been talking to her.

MS. SULLIVAN: We need a girl, we need a girl.

MR. SEGER: Thank you very much.

MS. KADE: Thank you very much. You all try and take a look at that car. If you want additional information, Toian can send it out to you.

We're going to open it for public comment. Dan Fisher? Dan Fisher, and then anyone else who would like to join in.

DR. FISHER: I'll be very brief. I'm the Executive Director of the National Empowerment Center. I just wanted to report on some work that we did down in Louisiana so that SAMHSA knows. This was supported by SAMHSA.

We did two trips to Louisiana. In the first one, they identified they wanted peer support training among the consumers in Louisiana, so that they could then provide peer support to other consumers in the affected areas.

October 18th to 20th, we convened three national leaders to go down and do training for 45 consumer leaders in Louisiana in New Orleans, Lafayette, and Baton Rouge. We worked with the commissioner there. As a follow-up, we developed part of their FEMA grant to have peer support be part of the grant.

I just wanted to say sort of for the council

and maybe for SAMHSA in the future that the emergency response and recovery center was helpful, but it's hard sometimes for them to recognize the importance of peers and peer support and peer counseling, although it's very highly developed in many areas of the country.

Sometimes, professionals are called on before peers are thought about, but in order to really reach out to many people in different parts of the country and develop a crisis plan, such as happened after 9/11 -- Project Liberty used peers a lot in New York City, and after the tornadoes and after the bombing in Oklahoma, peer counselors were used.

We see this as the way to develop more in the way of consumer-run organizations and peer support in affected areas, and also proactively now other states are using this information to set up the crisis planning that engages and involves consumers as peer counselors in the future. So you don't have to go down, rush down and provide the training at the time, but really do it ahead of time and have crisis services and crisis planning be part of that, because there are parts of the country where consumers are providing trauma-informed peer support on the theme that was done here with children. That's being done with adults now also by peers.

There is a write-up of this that people can

pick up in the back. It is on our website, howardu.org, if you want to see more information about resources about Katrina.

Lastly, there is a webcast that's being done using some of the people from Louisiana who have have done the training, and myself. It's December 15th and is sponsored by SAMHSA.

MS. KADE: Thank you very much.

Any other public comments?

MS. ROGERS: Hi. I'm Susan Rogers from the Mental Health Association of Southeastern Pennsylvania. I spoke a little about this yesterday.

I wanted to thank Barbara for her question about seclusion and restraint and what people are doing to get toward a zero policy. I wanted to again mention the special section in Psychiatric Services, September of '05. There was an article about Pennsylvania's initiative.

Pennsylvania is working toward moving to a zero seclusion and restraint policy. I would really like to respectfully just add that in Pennsylvania, we are trying to get to zero with that.

This initiative began after Mr. Curie was our head of our mental health system there. He was the one who initiated it. If anybody wants more information about how we are doing it in Pennsylvania, please get in touch with

me at the Mental Health Association of Southeastern Pennsylvania, srogers@mhasp.org. I'd be glad to email you information, or you can contact the state mental health authority. I'm sure they can provide that, too. Thank you.

MS. KADE: Thank you very much.

MS. THIEL: I'm Thelma King Thiel with the Hepatitis Foundation International.

I wanted to thank Dr. Clark and Beverly Watts Davis especially for inviting us to train a lot of their grantees. We are scheduled to train 250 more in January and we've already trained hundreds of them.

I also wanted to thank Ms. Jeb Bush for inviting me down to Florida to meet with the Drug Policy Advisory Council a few months ago. As a result of that, we have trained some of the folks, the counselors at the Juvenile Justice Department. We have done training programs along with a couple of the health departments, the Collard County Health Department, and I just was down there recently to the Hillsboro County Health Department, and they are going to invite us down again.

The response that we're getting on some of the evaluations that we had, we are promoting liver wellness as an effective approach to get people to change behaviors. We have done extensive evaluations. We're just delighted

at the response that we're getting.

I do want to thank everybody for collaborating with us. As a matter of fact, SAMHSA just gave a grant to the Latin American Youth Center in Washington, D.C. They had included us in their proposal and we're going to be training their staff.

Again, the bottom line on all of our drug use problems is changing people's behaviors. We've got a real good start on that. Thank you so much.

MS. KADE: Thank you very much.

If there isn't anymore public comment, I'd like to -- yes?

MS. STUART: Carolyn Stuart with CONTAC out of West Virginia at the National Technical Assistance Center.

I'd just like to say thank you for letting us be a part of this meeting, and just to comment in regard to the man with the Race Against Drugs. One of the things that (inaudible) because as I listened to his presentation, I realized that a large segment of the population will be left out, because African Americans generally don't pay attention to NASCAR.

MS. SULLIVAN: Not true. No, that's not according to the demographics now.

MS. STUART: Just keep it inclusive and ensure that it reaches a large segment.

MS. KADE: Thank you very much.

In closing, I want to summarize some of the highlights of some of the follow-ups that we promised you.

In response to the request, Mr. Curie agreed to provide printed copies of his remarks to the council members and that was done.

In request to a response from Mr. Stark, Ms. Power promised to provide copies of "Transforming Mental Health Care in America: The Federal Action Plan Agenda: First Steps," and also the IOM report to the council members. I believe that was done.

Mr. Curie asked for information on Medicaid Part D. We provided the presentation today. I am going to be following up. I'll try to set up a conference call with CMS before our June meeting, and we'll summarize the highlights and the issues from the discussion this morning.

In response to Ms. Sullivan's request, I offered to provide the SAMHSA scores on the OMB-mandated green standards for success. So what you have is an explanation of those standards and the overall scoring. That's publicly available information.

I think that's about it. There were other issues that you'll see in the minutes, but those were the immediate follow-ups.

Any others? Toian, do you want to add anything

else?

MS. VAUGHN: I want to thank everyone for coordination and the effort that they made. This is a full agenda with everything that took place.

We will be leaving here shortly. I hope that you'll have an opportunity to look at the Motorcraft as you exit the build and as you get on the van to go downtown, because I think this afternoon we are going to be visiting with the Secretary as he does his PSA announcement regarding the Katrina campaign.

I also have been informed that you wanted to visit the Secretary's command center, and we've made arrangements for those who are not leaving to do that as well.

MS. KADE: Then I call for an adjournment.

MS. SULLIVAN: Second.

MS. KADE: Thank you. See you in June, and talk to you earlier.

(Whereupon, at 12:06 p.m., the meeting was adjourned.)